NOVEMBER · DECEMBER 1954

children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

Interprofessional Understanding

Factors in Mental Retardation

The Polio Vaccine Trial

Services in the ADC Program

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A professional journal on services for children and on child life (*formerly* THE CHILD)

In her coeditorship of the fact-finding report for the Midcentury White House Conference on Children and Youth, Ruth Kotinsky exemplified her long-time concern with bringing together the contributions of the various professions to the development of the individual child. A distinguished writer on education, she has served on the National Council of Parent Education and on the staff of the Committee on Secondary School Curriculum for the Progressive Education Association.

Dr. George A. Jervis, who introduces CHILDREN'S series on the mentally retarded, has been working in the field of mental deficiency for the past 20 years. At Letchworth Village one of the oldest and largest State institutions for the mentally retarded in the country, he has had at first hand an abundance of material for his inquiries into the etiology and characteristics of the various types of mental defectiveness.

The research, professional training, and patient-care programs of the National Foundation for Infantile Paralysis all come under the direction of Dr. Hart E. Van Riper who herein describes the recent widespread testing of the Salk vaccine. With the Foundation since 1946, this administrating pediatrician was from 1941 to 1944 director of maternal and child health in the Children's Bureau, then in the Department of Labor. Later he served as medical director of a hospital in Miami, Florida.

The coauthors of the article on services to children in the ADC program have both had long experience in public welfare services. Before joining the staff of the Children's Bureau 8 years ago Mrs. Sandusky (left) had been consultant on children's services with the Illinois Public Aid Commission and head of the casework department of the Atlanta University School of Social Work in Georgia. Miss Foster (right), with the Bureau of Public Assistance for 3 years, was previously supervisor of field services for the Washington State Department of Public Welfare.

An expert in quantitative analysis, Edward E. Schwartz in this issue tells why available figures on juvenile delinquency are not entirely reliable. Demonstrating the usefulness of statistical methods has absorbed a major portion of Mr. Schwartz's attention in his 13 years with the Children's Bureau and in the 5 years he spent as regional consultant for the Bureau of Public Assistance. His M. A. is from the University of Pittsburgh.

Considerable first-hand experience in well-child conferences has convinced Marie Goik of the importance of understanding the emotional and social factors which affect a mother's relationship to the child. Before taking her present position, she was Nurse Consultant in a Commonwealth Fund project on mental health services for children in the University of Louisville School of Medicine, Louisville and Jefferson County Department, and Kentucky State Department of Health.

Widely known as a parent-group leader and speaker on human development and mental hygiene, Ralph H. Ojemann is directing a research project in education in human relations and mental health.

frontispiece

NEW HOPE for the prevention of poliomyelitis which has left this little girl with partial paralysis is centered on the vaccine tests described elsewhere in this issue. But even though the vaccine proves completely reliable and is widely adopted as a public-health measure, large numbers of victims of past scourges of the disease will still require treatment and rehabilitation. Such services are today provided both by the National Foundation for Infantile Paralysis and the State crippled children's services, the division of responsibility depending on individual State agreements with the Foundation. In 1953, some 30,000 children under 21, many of whom had contracted the disease in previous years, received service for the acute or later effects of poliomyelitis from the Crippled Children's Services. In that year there were approximately 36,000 new cases of the disease among children and adults.

—Photo by Esther Bubley for the Children's Bureau.

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Good service requires good teamwork among various professions. Here is suggested . . .

AN APPROACH TO INTERPROFESSIONAL UNDERSTANDING

RUTH KOTINSKY, Ph. D.

Former Assistant Director of Fact-Finding, Midcentury White House Conference on Children and Youth

ALL THE PROFESSIONS that deal with human beings aim to help them achieve the utmost of their potential for living not only adaptively but also creatively in their society, participating in it as fully as they can, and achieving optimum satisfactions in the process. Broad aims held in common are likely to lead to the presupposition of broad common professional understandings—presupposition of a wider common background than the facts of professional education warrant.

For example, the teacher has to know how the child develops and so does the social worker. Both have had training in this area, and so presumably have at least this much in common. Actually, most teachers have been schooled in a brand of child development that emphasizes the kinds of behavior to be anticipated at various ages or developmental levels, without interpretation of observable phenomena or rationale for their sequence, whereas social workers have ordinarily been steeped in what has come to be known as "dynamics."

Each talks to and with the other as if they held a common understanding, when in fact they do not. Actually each is an adherent of a different school of thought about human behavior and what gives it its characteristic bent. And when two persons, each with a different theory of behavior, try to work together with regard to the behavior of a third, trouble is bound to brew—most importantly perhaps for the third, but also in the relationship between the two.

Then, in part because of an actual lack of understanding of the dynamics of development and behavior on the part of teachers, and in part because the schools have of late become so avid for mental-health furbishings, the social worker (or occasionally the clinical psychologist or psychiatrist) has had a try at imparting new insights and understandings to teachers and principals. Here all the resistances to being moved in on by an "outsider" come into play. Moreover, in this effort, the social worker is scarcely in a position to follow what is perhaps the first rule of teaching, namely, to begin where the learners are.

He does not have at his command the whole conceptual framework that lies behind the teacher's teaching and the principal's conduct of the school. He cannot therefore build upon it, helping teachers to reconstruct it where they think necessary after having been exposed to new knowledge and brought to new sensitivities through their contact with him. Unaware of a conceptual framework, he is all too likely to speak as though it were not there. It is impossible for him to distinguish between the educational ideal and its all too imperfect realization.

It is, for example, no longer necessary to explain to a teacher that a child is best approached with respect rather than with hostility and contempt, and that any approach to him must be geared to his current level of development. These have been theme songs in his education as a teacher. If he still does not treat his pupils with respect and adapt to them as children, as indeed he may not, the reason must lie elsewhere than in his training, and one more lesson is not very likely at last to turn the trick.

This article is excerpted from a paper presented at the 1954 Forum of the National Conference of Social Work.

Social work is often an adjunctive, and nearly always a cooperative, service; but an adjunctive service is impeded, and cooperating services lose much that they might gain, as long as the different services start from different premises, taken as axiomatic, about the sources of human behavior. When to this there are added a general lack of sociological information about the potentialities and limitations of professional groups and institutions for bringing about social change and some vagueness with regard to the spread and limits of specific professional function, the possibilities for interprofessional irritation are many, and the need for some drastic interdisciplinary setting of the house to rights is thrown into sharp relief.

Contrary Assumptions

Each institution and profession consciously directed toward the shaping of human behavior has grown up out of specific social exigencies, has been shaped by different influences, has developed its own tradition, values, mores, sacred cows and taboos, language, assumptions taken as axiomatic, framework of deduced conceptions, ingroup cohesion and outgroup antagonisms. Among such islands, communication tends to be blotted out by static.

If assumptions in regard to the forming of human behavior were readily put to the test we should be in no such great difficulty. The assorted disciplines that treat of the physical and biological worlds are not so bedeviled by basic assumptions that lie sometimes contrariwise, the one to the other, and sometimes obliquely, in bewildering patterns and frustrating *culs de sac*. Each may have its own symbols, but semantic problems are practically nil because each symbol either has a direct operational referent, or a defined relationship to other symbols which have such referent in the outer world. When a problem calls for cross-fertilization from two such fields, like chemistry and biology, there is no great pother of misunderstanding, misinterpretation, working at cross-purposes, and mutual denigration. It is necessary only to contrive methods that bridge the mutually accepted assumptions.

For the sciences that bear on human behavior there is as yet no methodology for moving past all possible or probable doubt. Some clinical evidence there is, but that is empirical only, and concentrated largely on deviate or pathological instances. Some laboratory evidence there is, but man is a social and not a laboratory animal. Unlike other animals, he lives only in and through a cultural medium. Some statistical evidence there is, but it must be highly suspect because human behavior, insofar as it is understood at all, seems in no way reducible to discrete units, the very stuff of statistical method. Out of much experience with an assortment of approaches, none of them either entirely appropriate to their material or entirely satisfactory as science, a new Bacon of the sciences bearing on the behavior of man may emerge. But that time is not yet.

What then of the meanwhile? The interdisciplinary approach has long been bespoken, and has as yet, as far as I know, nowhere fully succeeded. Yet it seems to me of such great worth as to warrant still more tries, with as great resources as can be found to back them up, and as much preexploration of the difficulties as possible. This I call to the special attention of the profession of social work, in part because it draws upon a number of disciplines, but so do all the other arts of healing, amelioration, and guidance. More especially, the opportunity seems challenging to social work for two other reasons. One of these is enduring: Since much of professional social-work practice is adjunctive, of necessity, social work operates often in the context of assumptions other than its own, and in a number of such contexts, each of which differs from the other. This in itself provides opportunity, stimulation, and challenge. The other reason for posing this problem to the field of social work is more ephemeral: The fleeting moment of setting the pattern of its doctoral work is at hand.

The interdisciplinary approach in professional education already has been tried in several ways. A relatively time-honored one is to throw several books at a young student at once, and leave the job of integration to him, as though to say, "We seasoned folk can't make it; you try." In this implied exhortation there may be a grain of wisdom, but the fact of the matter is that the young student has neither the capacity nor the occasion to try. Somebody lectures in psychology; somebody else lectures in sociology; somebody else lectures in anthropology, and maybe history and economics and the dynamics of behavior. It is all very interesting, and if one is very bright, one can keep this whole assortment of hats around to pull something out of when one phenomenon or another needs explaining. The fact that the hats don't fit together very well is of no immediate concern.

Another system consists of steeping a student in a stimulus-and-response psychology, trial and error,

fumbling and success, assuring him that this is the way all learning takes place, and that learning involves the reconstruction of the self—and then sending him out to observe in a guidance clinic that rests upon quite other premises about the nature of the self and the ways in which it changes. Here again are a couple of hats into which he can dip at will.

Other attempts have been made much further along the scale of professional maturity. These have been of many different orders. Sometimes a covey of scholars from assorted fields has been brought together for a short time in order that the translucence of each and all may illumine a given project. Ordinarily, it takes much editorial legerdemain to obscure the resulting Babel. More occasionally mature scholars have come together over long periods of time, seriously dedicated to joint study and research. Most often they have soured, sickened, and eventually turned in desperation each to his own laboratory in order once again to have the feel of getting something done.

This is where the bit about "We can't do it; you try"; fits in. The mature professional has apparently given himself in hostage to the skills and techniques, horizons and perimeters that have served him well to date. All the books on adult learning say that this should not be so and need not be so, but apparently in the vast majority of cases it is so nonetheless. Efforts to widen the horizons in ways that may necessitate acquiring new skills or overhauling old ones prove threatening, and tend to be met with resistance, either overt or in the form of a profound apathy.

It would begin to look, then, as though we must revert to the young student whose professional self is not yet formed, and surely not hardened into a rigid mold. Insofar as we have succeeded in integrating the findings from the assorted disciplines related to the study of human behavior, these integrations can, of course, be passed along to successive generations of students. But the day on which we shall have very much such integration seems still far off. In the meantime, it would seem the better part of wisdom to acquaint students—probably even undergraduate students, but surely graduate students—with the discrepancies among the disciplines, the *lacunae* in our knowledge, the extreme tentativeness of all the hypotheses on which all workers in the area of human behavior must now operate.

This of course is being attempted in some places. In time, it may obviate some of the hard-set-in-a-moldness that now seems to characterize too many of those advanced in practice. Also, for some students, it will pose a challenge which might otherwise elude them, and so stimulate to research at profounder levels as the years go by. There is, of course, the possibility that action will be paralyzed if the grounds upon which it rests are early recognized as shaky, but this possibility seems to me remote.

Somehow the field of biology survives, and active and fruitful work goes on within it, despite the fact that students are introduced early to the evidence that leads to various and differing theories of evolution. Moreover, in everyday life, decisions are made hourly without sufficient evidence to go upon. Man acts because he has to act.

An Opportunity

So far I have been thinking about students below the doctorate level. It would be my guess that if such students were versed in the theoretical discrepancies upon which all practice relating to human development and behavior rests, they would, when the time came for them to practice, arrive at mutual understanding more readily, and that the articulation of their efforts would prove more beneficial for those whom they are trying to help and more enriching and mutually rewarding to themselves.

But still little would be accomplished toward the integration of basic theory. Here is where, hopefully, the new social-work doctorate comes in. By long and respectable tradition, the doctoral candidate must make a contribution to knowledge. By another long and less respectable tradition in fields relating to human behavior, this basic requirement has been reduced to a travesty. A contribution is equated with research; research is defined as the employment of research techniques; research techniques are borrowed from fields where they belong and applied in a field to which they are not opposite. The only urgent problem the student really feels is to get his degree, and the Ph. D. candidate in search of a problem to which the research techniques he is obliged to use can somehow be applied is unfortunately not a rare academic bird. In the long run he usually hits upon something, no matter how trivial, puts his tools to work, and comes up with a correlation coefficient plus or minus something. By definition, he has made a contribution to knowledge. Under these ground rules, both Bacon and Darwin would have flunked.

It is easy enough to say that there are not many Bacons or Darwins among candidates for the doctorate. It is harder to set the stage for the emergence of some potential Bacon or Darwin. There is, of

course, a need to train a certain number of people for administrative posts and for a kind of evaluative research which, however crude, is the best now available for gaging the worth of programs and giving direction to practice. People have to be trained; once trained, they have to be certified as such, and perhaps this is what most doctorates must continue to represent.

My sole plea here is that, in all professional fields that bear on the behavior of man, some major emphasis be put upon seeking more genuine contributions to knowledge through the interdisciplinary approach. This would call for rich resources, and not in money alone. It would siphon off the most sensitive, insightful, intelligent, and creative of candidates, and it would be doomed to failure if faculty members, plagued by committee meetings, had no time for the arduousness of scholarship or no stomach for its frustrations. It would also demand the sacrifice of one of our sacred cows, according to which it is wicked even to whisper: "We do not know. We do not yet have the evidence for certainty. We have come upon some obstacles that have us stopped for the time being."

Possible Inquiries

The lines of investigation that might be pursued are manifold. A delineation of basic assumptions taken as axiomatic in any and all fields of related practice is one. It would involve their systematic examination and the attempt to array them as alternative hypotheses, despite all semantic bedevilments. It would lead eventually to an extended search for methods of testing these hypotheses.

There is also much to be learned about how institutions arise and take and change their characteristic forms, and about the role of the professions in this connection. In the long run we must know whether to fish or cut bait on our professed professional obligations to contribute to the orderly amelioration of the shape of social things. With better understanding of how human beings develop and change and how social institutions develop and change—or even with no more than a clearer grasp of alternative hypotheses on this score—it should be possible to delineate far more clearly the distinctive contribution of each professional field to shared goals in terms of human values.

All this will entail full use of the resources that lie in a university. Clearly a good deal of the inquiry proposed will have to be conducted in an interprofessional setting. But all these professions rest, each in its own way, upon the findings in a series of so-called "pure sciences" or disciplines—psychology, sociology, anthropology, and all the rest, all fully represented in the university. Therefore, if inquiry is to plumb beneath the surface in any of the professions, it must needs proceed hand-in-hand with the supporting pure disciplines.

The use of university resources after this fashion is undoubtedly far easier said than done. The university has its own traditionalisms, as does each school and department within it. Professional acculturation is perhaps hardest-shelled in the university, where it is to a degree protected from the stubborn unclassifiability of social life on the hoof. Hard-gained techniques and cherished axioms are less threatened when the academic walls are built high around each school and discipline. Moreover, one folk axiom is hard to call into question—"once bitten twice shy"—when it comes to interdisciplinary effort.

On the other hand, the university tradition is made up of assorted strands, and one of these that still stands out bright in the pattern is the rigorous search for truth. The rigor need not represent only implacability in face of the spurious, but also an inflexible determination that no half truth shall stand so long as a larger fraction may be found. No doctoral candidate with a truly searching problem, a rich background, and some evidence of genuine creativity should find himself out in the cold when his work requires the concerted critique of scholars from a number of disciplines. And the same should hold of research conducted by any advanced professional school in a field where problems are many and complex, action is imperative, and gaps in knowledge are in many respects absymal.

Doctor's theses in these circumstances will necessarily take on a tenor quite other than their currently monotonous clatter of computing machines, and a design that must reach further than the agglomeration of pious footnotes. Fewer will come up with answers. More will come up with questions. Some may have to give serious account of why not even useful questions could be formulated. The risk that a fraction of them will turn out pure balderdash will have to be taken, and consolation found in the fact that the fraction will probably be no greater than under the present stereotype. The whole will be a severe headache and a test of human endurance, but in my estimation worth while as a means of helping genuine scholarship to begin to come into its own in the professions that deal with human behavior.

What can be done for children who are mentally retarded? The question is being urgently pressed today by parents who are not willing to assume the long-accustomed attitude that children thus disadvantaged should be hidden away in shame; and by others who believe that all children, even those whose capacities are extremely limited, should receive opportunities for achieving their maximum potentialities.

CHILDREN plans to explore this question in a series of articles in forthcoming issues by persons engaged in various aspects of work with mentally retarded children and their parents. Because an understanding of any problem is a prerequisite to an intelligent consideration of efforts toward its solution or alleviation, the series is being introduced with this article defining the phenomenon of mental retardation—insofar as it can be defined—and presenting its known and suspected causes.

FACTORS IN MENTAL RETARDATION

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VARIOUS SCIENCES have contributed to our present concept of mental deficiency. For a long time sociologists have observed that there are individuals who, since childhood, have been socially incompetent and incapable of adequate self-support. Psychologists, coming later, have noted that this social incompetence is often associated with defective intellectual development. They have discovered ways of measuring the degree of intellectual deficit and of establishing certain correlations between intellectual endowment and social attainments. Then as medical science advanced physicians became increasingly aware that some diseases occurring during fetal life or in infancy may result in lesions of the brain with consequent mental defect. Finally, with the advent of the science of human genetics the relevance of genetic factors in determining deviations of intelligence emerged.

Mental deficiency may be defined as a condition of arrest or incomplete mental development existing before adolescence, caused by disease or genetic constitution and resulting in social incompetence. This definition includes both the sociological concept which stresses the social inadequacy of the defective, and the psychological concept which is considered in the term "arrested" or "incomplete" mental development. The biological viewpoint is embodied in the mention of genetic factors and diseases.

Intellectual impairment developing after adolescence is not usually known as mental deficiency but as dementia, a customary differentiation for more than a century in both legal and medical thinking, in spite of its dubious validity.

Thus defined, mental deficiency is not a single condition, but a symptom common to diverse conditions of disparate etiologies and of various manifestations.

In the recognition of mental deficiency, the results of psychological examination play the leading role. The mental age (MA) is determined by psychometric tests and the intelligence quotient (IQ) calculated as

the rapport of the mental age to the chronological age (CA): $IQ=\frac{MA}{CA}100$. Other factors besides intelligence quotient are taken into consideration, such as educational attainment, emotional reactions, general behavior, and social adjustment. The information from both familial and personal history is carefully evaluated. Finally, a complete medical examination is performed, using modern techniques of clinical and laboratory medicine. It is upon the evidence thus collected that the diagnosis is made.

Considerable difficulty is often experienced in diagnosing the borderline cases between "subnormality" and mental deficiency. The criterion of social adjustment is decisive in these instances.

Incidence and Classification

In estimating the incidence of mental deficiency, a great deal depends upon the criteria of diagnosis used in the assessment of defective individuals. For instance, if the criterion of social incompetence is adhered to, the incidence will be higher in a strongly competitive urban environment than in rural communities. If a purely psychological criterion is adopted, the test used and the arbitrary point of demarcation between the defective and the nondefective individual will determine to a large extent percentage figures. If one accepts an IQ of 75 instead of one of 70 as the lower limit for the nondefective, the percentage of defective population will be over twice as large. Estimates based on institutional censuses are obviously inadequate and always too low, since only a fraction of the mentally defective population is institutionalized. Those based on large-group testing of school children have their limitations and are perhaps too high. Accurate surveys using modern techniques of securing data and uniform criteria of evaluating intellectual and social development have been few in number and limited in extension.

On the basis of scattered and incomplete data collected from many sources, it may be assumed that the incidence of mental deficiency in the general population is around 1 percent, using IQ below 70 as the criterion. This figure yields a total of 1,500,000 mental defectives in the United States.

Defectives are usually classified into three groups—idiots, imbeciles, and morons, but the corresponding terms of low-grade, medium-grade, and high-grade defective are to be preferred. Defined in sociological terms and in the language of the English Mental Deficiency Act (1927), idiots are persons whose mental defectiveness is of such degree that they are unable to guard themselves against ordinary physical danger. Imbeciles are persons whose mental defectiveness, though less extreme than in idiots, still prevents them from managing themselves or their affairs, or, in the case of children, of being taught to do so. Morons are persons whose mental defectiveness, though not amounting to imbecility, is yet so pronounced that they require care, supervision, and control for their own protection or for the protection of others, or, in the case of children, appear to be permanently incapable of receiving proper benefit from instruction in ordinary schools.

In more precise psychological terms, an idiot is a person having a mental age of less than 3 years, or, if a child, an intelligence quotient of less than 20. An imbecile is a person having a mental age of 3 to 7 years, inclusive, or, if a child, an intelligence quotient from 20 to 49, inclusive. A moron is a person having a mental age of 8 to 11 or 12 years, or, if a child, an intelligence quotient from 50 to 70 (or 75).

Although of considerable value in dealing with practical problems of defectives, both sociological and psychological classifications present limitations, being purely descriptive in character. More comprehensive are medical classifications which follow mainly etiological criteria, grouping patients according to the cause of the defect. While this type of classification may offer considerable difficulty in individual cases, because of scanty and contradictory etiological data or the fact that more than one etiological factor may be responsible for the defect, it does bring about a better understanding of the problem in relation to preventive measures.

Etiologically, mental defect can be divided into two large groups—endogenous or primary, and exogenous or secondary. In the exogenous group the defect comes chiefly from environmental factors. This group can be subdivided into types according to the causative agent—infectious, traumatic, toxic, and endocrine. On the other hand, an endogenous defect is determined mainly by those hereditary factors known as genes. The group includes conditions due to the combined action of many genes each of which alone would have an insignificant effect, or to the action of a single dominant or recessive gene.

Hereditary Defects

Multiple genes. Mental defects determined by multiple genes are "undifferentiated" in that they carry no specific physical distinction and are "aclinical" in that they show no clinical manifestations

other than intellectual impairment. This group has also been designated by other terms: "residual" because it is composed of individuals who are left after a classification of specific forms; "subcultural" because so many of its members originate from low cultural environments; "familial" because of the high frequency of the condition in the patients' families. Since these cases can be diagnosed only by psychological and social adjustment criteria, differentiation between high-grade morons and dull-normal individuals may be difficult. While antisocial behavior and psychopathic traits occur in the group, they are far from universal.

Estimates of the incidence of undifferentiated mental defects run between 30 and 75 percent of all the mentally retarded, the lower figure probably running nearer to the facts. It includes defects of all grades, but high-grade morons predominate.

While the etiological factors determining the large number of undifferentiated cases of mental deficiency are still in dispute, it seems likely that they are similar to the factors responsible for general intelligence—in other words, genetic constitution. It seems reasonable to assume that most of these undifferentiated cases represent merely the lower part of the normal frequency-distribution curve of intelligence, known to statisticians as the Gaussian form. This means that a certain number of individuals are bound to appear in the range below the line indicating IQ 70. They are an integral part of the population as a whole, just as are individuals with superior intelligence with an IQ above 130. According to the curve, the majority of undifferentiated defectives are in the moron classification with IQ's between 50 and 70, and only a very few at the idiot level, with IQ's below 20—a picture which corresponds to observed fact.

Genetic constitution, however, is not the only source of all undifferentiated defectiveness, for environmental factors, such as subcultural milieu and poor hygienic conditions, undoubtedly play a causative role. The task of tracing the source of the defectiveness in individual cases is not easy, particularly when malnutrition and deprivation have been in the picture.

Single genes. Some differentiated defects are determined by the presence of a single dominant gene transmitted from parent to child. Such defects are always traceable in the family history unless of a type that prevents reproduction. Frequently they turn up in severe form in alternate generations occurring in the intermediate generation only in incomplete form. Sporadic occurrences in families with no history of the defect are probably caused by a new mutation in a parental germ cell.

Data collected at Letchworth Village indicates that dominant genes probably account for only about 1 or 2 percent of all mental defects. These are always characterized by some physiological changes which make them classifiable into specific or clinically recognizable diseases. Among them are tuberosclerosis, neurofibromatosis, and nevoid idiocy—diseases in which mental deficiency is accompanied by skin lesions—and several forms of mental defect characterized by changes of bone structures.

There are also clinically recognizable defects caused by the presence of two similar genes, known as recessive genes, one from each parent. Since persons of blood relationship are more likely to carry similar genes, such defects occur more frequently among the offspring of consanguineous marriages than in the general population.

In the great majority of the recessive cases the parents themselves are normal, being merely carriers of the gene, or, in genetic terms, heterozygous for the gene. The defect is characteristically distributed among 25 percent of the sibs, and is sharply distinguishable. While such defects are on the whole rare, they include a number of specific diseases: amaurotic family idiocy, a progressive and fatal disease accompanied by blindness which, according to type, may show up in infancy, childhood, or adolescence; gargoylism, a disease characterized by mental deficiency and grotesque bone changes; phenylpyruvic idiocy, the result of an inborn error in metabolism of an amino acid; hepatolenticular degeneration, a progressive form of mental deterioration caused by degeneration of nuclei at the base of the brain; and some forms of diffuse sclerosis, also a progressive disorder causing brain damage.

Environment-Produced Defects

A large but not yet clearly determined proportion of defectiveness comes from factors outside the hereditary constitution including infections, trauma, poison, glandular disorders, and physical or emotional deprivation. Rough estimates, based on unpublished data from a number of institutions indicate that such factors may account for at least half of the mentally retarded population in the country.

Infection. Brain damage resulting from infection from the nervous system may occur in the womb or during infancy or childhood. The type of infectious agent, the severity of its attack, and the age of

the child when attacked determine the degree of damage.

One of the most prevalent of such infections used to be syphilis, transmitted during gestation from an infected mother through the placenta to the fetus and resulting in brain damage to the fetus and later mental defect in the child. While syphilis still is responsible for a small percentage of all defectiveness, the proportion of infected children has already been reduced by venereal-disease control programs and undoubtedly will be further reduced in the future. Especially effective has been the increasing adoption of routine serological tests of pregnant women, prescribed by law in many States.

One form of severe mental deficiency comes from rubella infection (German measles) in the mother during the first 3 months of pregnancy. Besides the intellectual impairment resulting from fetal brain damage the rubella virus's attack on the fetus often produces congenital deafness, anomalies of the heart and eyes, and microcephaly (undersized head and brain).

Facts about the effects of other virus infections of the mother on the fetus are not so definitely established. It is possible that some other viruses may act in a manner similar to that of the rubella virus.

Brain fever is estimated to be responsible for the mental defects of 10 to 20 percent of all institutionalized defectives, according to Letchworth Village data. Caused by one of the encephalitis viruses or by a bacteria, such as the meningococcus of meningitis, it often strikes in infancy and childhood. While many children recover from it completely and others die, some recover with permanent impairments, the most common of which is mental defect. Measles, scarlet fever, chickenpox, whooping cough, influenza, and other communicable diseases common in childhood also occasionally leave brain damage.

Patients whose mental defectiveness has resulted from acute attacks of these diseases are usually referred to as post-encephalitics. The degree of mental defect among them varies considerably with the individuals. Many of them exhibit a peculiar behavior pattern marked by episodes of overactivity, restlessness, impulsiveness, assaultiveness, and wanton destruction.

Trauma. While accidents resulting in injury to the brain may sometimes occur in infancy or early childhood they are insignificant in comparison to injuries at birth or in the neonatal period as a cause of mental defect. Cerebral trauma during birth has been variously estimated to cause from 10 to 50 percent of all defectiveness. However, the incidence in institutionalized defectives does not seem to be above 20 percent. According to data gathered by the United Cerebral Palsy from one-half to two-thirds of the children in the general population showing evidence of birth injury are not mentally defective.

Difficult labor and prematurity are the most frequent causes of brain damage during birth, the former because of the risk of mechanical injury and the latter because of the immaturity of the brain. An immature brain is more prone to damage.

Brain damage at birth comes either by asphyxia or by hemorrhage. Asphyxia, which must be present for a relatively long period to produce irreversible damage, may result from premature separation of the placenta, cord complication, overdosage of the mother with analgesic drugs, or delayed breathing by the newborn. Hemorrhage, which may be within the brain or its envelopes, comes from direct injury during delivery—by forceps, or by a tearing of the tentorium, one of the membranes of the brain, in compression of the head during its passage through the pelvic canal.

Toxic causes. Little is known about the effects of toxic factors transmitted from mother to fetus during pregnancy, but evidence exists for suspicion that there are several ways in which fetal poisoning, resulting in malformation and mental defectiveness, may occur. Eclampsia, a severe intoxication of obscure origin suffered by some pregnant and delivering women, may affect the child detrimentally. Some toxic drugs taken by a pregnant woman may also damage the fetus but what these are and how great the dosage must be to be damaging are still mysteries.

X-rays, on the other hand, are definitely known to be damaging to the developing central nervous system. Several cases are on record of mothers who after receiving deep X-ray therapy to the abdominal region during pregnancy have produced microcephalic children or children with other congenital abnormalities, including mental defect. However, improved knowledge of the effects of X-rays has resulted in the routine testing of women of childbearing age for pregnancy before radiation, and thus in the reduction of defects from this cause.

Blood incompatibility between mother and child also has a toxic effect upon the child. This comes about most frequently as a result of the Rh factor, an entity present in the blood of about 85 percent of the population, but absent in the other 15 percent. When an Rh negative mother (whose blood possesses

no Rh factor) carries an Rh positive baby, toxic substances develop which may cause damage to the fetal blood, liver, and brain. However, this condition is responsible for less than 1 percent of low-grade spastic defectives, as fortunately only 5 percent of Rh-positive children of Rh-negative mothers develop the disease, while some who do develop it recover completely.

Mongolism, or mongoloid idiocy, a condition with a characteristic physical appearance, may also be toxic in origin, although little is definitely known about its etiology. Some authorities believe that the condition appears in the fetus before the third month of pregnancy as a consequence of a variety of toxic conditions inherent in the mother and associated with advanced age, endocrine disorders, or pathological lesions of the uterus. Mongoloids comprise about 5 to 10 percent of all defectives. Their IQ usually runs between 15 and 40. Because these children are prone to infection, they have a higher mortality rate than other defective children.

Endocrine disorders. While a certain percentage of mental defectives suffer from some glandular dysfunction, the proportion of defectiveness caused only by endocrine disorders is small. Cretinism is a form of mental defect definitely traceable to hypothyroidism or impaired function of the thyroid gland, either because of its lack of development or early destruction. This disease, which is also distinguishable by physical appearance, is endemic in areas where goiter is also prevalent, but it also occurs sporadically elsewhere. Dysfunction of the pituitary gland also causes mental defect, the most common type, Frölich's syndrome, being characterized by obesity, underdeveloped genitalia, and mild intellectual impairment.

Deprivation. Emotional deprivation, frustrations, and insecurity may not only bring about a condition among normal children resembling mental defect but may cause incorrect estimate of the intellectual abilities of high-grade defectives, especially those also physically handicapped. Pseudo-feeblemindedness is produced in normal children so deprived by an emotional blocking which responds to psychiatric treatment.

The most severe form of pseudo-feeblemindedness, infantile autism, is dramatic, if rare, evidence of the importance of emotional factors in the development of intelligence. Children so affected behave like idiots, do not talk, respond to stimuli, nor engage in any activity requiring intelligence, even though their intellectual capacity may be normal or better than average. Psychiatric examination shows that their apparent defect is a form of withdrawal.

The classical case of Kaspar Hauser exemplified the degree to which deprivation of the means of learning could impair intellectual development. Such extreme cases are not likely to occur today. Nevertheless, deprivation of cultural stimulation in some isolated communities still plays a role in producing the apparent low level of intelligence among the populace. More tragic are the effects of such deprivation on patients with disabilities interfering with academic learning. False diagnoses of feeblemindedness too often occur among children whose only impairments are in hearing, reading ability, word comprehension, minor motor handicaps, or other disabilities. In these children emotional factors are undoubtedly also contributing to the picture of apparent intellectual defect.

The Individual

In spite of the growing knowledge of the causes of mental defects few specifics are available for their treatment or prevention. As the foregoing shows, mental retardation is not an entity itself, but a characteristic of a variety of conditions, each with a different cause. Moreover, in each form there is a wide range of intellectual ability.

Prevention for some forms may lie only within the scope of eugenic measures, though more scientific knowledge in the field of human genetics would be required before such could be confidently prescribed.

Greater possibilities for preventing the exogenous forms through medical and public-health measures may be expected to be realized as knowledge of intrauterine life and development increases.

While treatment in the strict medical sense can be applied only to a small number of mentally defective individuals, in the broader sense of care and training it can be applied to all. But such a wide variation of conditions exist among children with mental defects that what kind of care and treatment each receives must be determined individually in line with a prognosis based on an accurate diagnosis of the case. While the goal can rarely be cure, it can almost always be improvement or the achievement of the maximum intellectual and social functioning of which the individual is capable.

A new experience in public health . . .

THE POLIO VACCINE TRIAL

HART E. VAN RIPER, M. D.

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"NEVER BEFORE have I seen such cooperation. Every doctor, every nurse, every volunteer, was at the proper place at the proper time. I was just a bystander."

The man who spoke was a county health director in one of the 217 test areas in 44 States included in the polio-vaccine study of last spring. In minimizing his own efforts as the pivot of the operation in his county, he was expressing the gratification of a professional person who had witnessed for the first time the participation of numerous nonprofessional volunteers in a medical-research project.

The results of the nationwide vaccine validity test, involving records on 1,800,000 children, cannot be known until sometime in 1955. But apart from its medical implications, this huge study has written instructive chapters in the history of community action. While the actual conduct of the trial was under the jurisdiction of State and local health officers in cooperation with the National Foundation for Infantile Paralysis, the active cooperation of many people in many walks of life was essential to its success.

Briefly, the objective of the field trial was to determine to what extent the killed-virus vaccine, developed by Dr. Jonas E. Salk, National Foundation research grantee at the University of Pittsburgh, protects children from paralytic poliomyelitis under natural conditions of exposure. The vaccine's safety and its ability to produce specific polio antibodies in the blood had been demonstrated in extensive laboratory, animal, and human tests. But scientific advisers of the National Foundation for Infantile Paralysis decided that it could not be presented to physicians as a preventive agent against polio until its validity had been proved through field tests involving at least a half million children. The resultant field trial, largest of its kind ever conducted in this country, produced many lessons for the conduct of public-health programs.

First of these is that nowadays it need not take years for a new medical concept to be adopted. In a relatively short period of education, a great many people were willing to accept for their children a trial vaccine.

According to preliminary reports, 655,412 boys and girls, or 59.2 percent of those eligible for the test, reported for the first inoculation in the series of three. Although records are not complete at this writing, apparently only an insignificant number of these failed to show up for their second and third "shots," 1 week and 4 weeks after the first.

Percentages of participation varied from a low of 33.6 in one county to well over 80 percent in several areas and a high of 98.2 in a single county. In areas where a thorough public-education program was carried out early, the number of children participating usually was high. While everyone had been exposed to reports in the news, radio, and television, face-to-face contacts at local meetings with doctors, school people, and National Foundation workers and trained volunteers "clinched the deal." Briefing sessions and special literature also helped, but no pressure was exerted.

Parents or guardians were required to sign a request form before their children could participate. Some parents were so anxious for their children to have the vaccine that when their physician concurred they did not even let illness interfere. Youngsters recovering from measles or mumps were brought to the door of the clinics for inoculation. In some places

Production of the Salk vaccine requires strict measures to safeguard it against pollution. Here, behind the forbidding sign, laboratory workers add polio virus to nutrient 199, a synthetic mixture composed of over 60 chemicals, in which the virus rapidly grows and multiplies.

vaccination teams were sent to hospitals to give injections to children who were patients there.

Among less educated groups the loss rate after the first inoculation was highest. Many of these were people who lived in remote places and were inactive in community life. Lesson number two for community programs is that more effective ways must be found to reach such groups.

Planning at the national level took place over a period of many months with the Vaccine Advisory Committee of the National Foundation and other NFIP medical committees, with committees of the Association of State and Territorial Health Officers, the Public Health Service and the Office of Education of the U. S. Department of Health, Education, and Welfare, medical societies, nursing associations, commercial laboratories that were to produce the vaccine, and other professional groups concerned. The testing of this new vaccine on a mass scale would not have been possible without the advice, support, and collaboration of the great majority of the Nation's leading medical, scientific, and health authorities.

The task of orienting parents and the community at large to the forthcoming trial began long before plans had jelled, even before the project was an absolute certainty. Detailed and authoritative material was distributed to the press as each step was taken. Leaders of national women's organizations and men's service clubs were asked to explain the field trial to their State and local affiliates and to enlist cooperation.

State health officers participated in picking the communities where the tests would be made. Selection was based on: polio incidence during the past 5 years among children in the 6-to-9 age group; size of population; local health resources for the conduct of the trial; and social, economic, and geographical factors. State health departments appoint their own vaccine advisory committees, while State and county medical societies were drawn into the planning. Doctors volunteered through their county medical societies to give the injections.

Each of the 217 areas of study was designated for one of two types of statistical control. In 126 of them, all children in the second grade of school were offered the polio vaccine, while children in the first and third grades served as the control groups. In the other 91 areas, involving about twice as many children, first-, second-, and third-grade school children were inoculated, but only half of them received the vaccine. The other half received a control solution, similarly packaged, but containing no vaccine. No one at the trial knew which fluid each child received. Blood samples were taken from approximately 2 percent of the children in both control areas, including some children in the control groups.

In the placebo-control areas the percentage of parental consent was lower. With only a 50–50 chance of their child receiving the real vaccine, parents were less eager to subject them to injections.

Interpretation

This system of scientific control presented a thorny problem of interpretation to the lay public. To lessen confusion and explain to each area its control system the Foundation issued a variety of materials. These included: an informational leaflet to accompany a special letter to parents, sent from the schools with the request form; a filmstrip with an accompanying Teacher's Guide, to acquaint children in the classroom with simple facts about vaccination; a filmstrip for adults. A third filmstrip and guide for the instruction of clinic recorders, prepared in an afterthought, was rushed out too late to do much good.

From these activities emerged another lesson: Educational tools must be completed early and an efficient system of distribution devised so that they will receive maximum use.

The experiment also confirmed the primary importance of face-to-face meetings with the public of

public-health officers, physicians, and volunteers in which questions can be answered directly and points of misunderstanding discussed.

In this project such meetings revealed that parents were predominantly concerned about the vaccine's safety. They had read that each batch of the vaccine had been triple-tested by the pharmaceutical manufacturers producing it, by the National Institutes of Health of the Public Health Service, and in Dr. Salk's laboratory. They had been assured by scientists that this meticulous testing and retesting had reduced the risk almost beyond calculation. They had been told that before the mass tests began, Dr. Salk had inoculated more than 5,000 children and adults in Pittsburgh without any harmful results. Yet, when medical skeptics in a few places questioned the vaccine's safety and when a radio and TV commentator spread a frightening and erroneous impression, they turned to their doctors and their community vaccine volunteer group for further reassurance.

Though many people did withdraw their children when the safety of the tests were challenged, wherever the local groups were accessible for prompt and frank answers, much of the doubt and uncertainty vanished. The press of the Nation did a splendid job of printing the facts about the vaccine's safety.

The original plan called for approximately 200 test areas. Eventually, 217 counties or parts of counties in 44 States were entered in the trial. In places where participation was withheld or withdrawn, the reasons were early polio incidence—the test could not be valid in places where polio was already occurring—or reluctance on the part of health officials or medical societies who still felt insecure about the vaccine. The spreading of rumors and erroneous information also had its effect. In a few smaller communities health officers felt they did not have the resources and facilities to handle the trial. In one instance, legal problems in connection with the liability of local health departments, doctors, nurses, and volunteers prevented participation, but such problems were successfully solved in all other selected areas.

After inoculation in a New York City school. Here as elsewhere the unpleasantness of the needle prick was dimmed by the sense of sharing in a common experience.

School Participation

The choice of schools—public, parochial, and private—for the location of inoculation clinics was the happiest of decisions. They provided the most feasible way not only of reaching thousands of children, but of making the experience easier for them. The vaccinations became a matter of school routine and the youngsters went through them together like little troopers. Schools took on a great deal more responsibility for the organization and direction of the clinics than had at first been expected. Superintendents, principals, school nurses, and teachers spent hours in rearranging schedules, setting up clinics, holding meetings, and superintending recordkeeping. They made this a "learning through doing" experience for both adults and primary-grade children. Altogether 14,000 public, private, and parochial schools participated.

The trial began on April 26. By early March National Foundation headquarters had compiled and issued to health officers a manual outlining in considerable detail the operating procedures which were to be followed in every community. This was followed up by 18 "Operational Memoranda" to cover the specific duties of health officers, school personnel, and the various volunteer chairmen. While there were some protests about the length and number of these detailed instructions, health officers were soon ordering the 58-page manual in quantity. The trial revealed that an operation of this sort cannot be spelled out too often, or in too many ways.

The trial also showed that even a national, uniformly planned, scientific test can provide a good deal of flexibility and room for initiative with States and localities. The overall plan called for a vaccine volunteers chairman in the locality to head up a group

of five chairmen of volunteer committees, covering: volunteer headquarters; transportation; public information; public education; school volunteers.

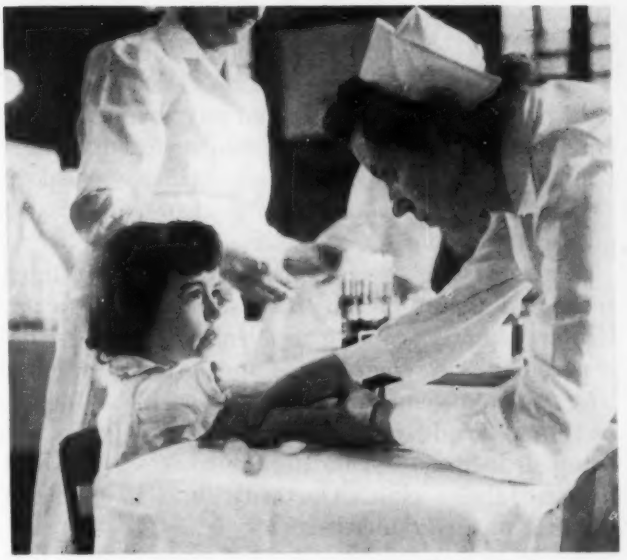
Keystones for the community organization and education were the National Foundation's local chapters and their numerous experienced volunteers. In most instances, these served as reservoirs of supplementary voluntary personnel for the local health officers. The presence of these permanent groups, part of the Foundation's network of 3,100 chapters made it possible to introduce a radically new procedure like the field trial on such short notice.

The variety of jobs carried out by volunteers included preparation and distribution of public information materials, clerical and telephone service, help in packing and repacking medical supplies, transportation of supplies, forms, or personnel to clinics or vaccination centers, recordkeeping and other duties in the clinic. In addition, the armbanded vaccine volunteers were instrumental in maintaining the level of attendance through the second and third inoculations by persistent followup of parents through "reminder" cards, telephone calls, or personal visits to homes.

In a few places professional people failed to use volunteers to capacity and called on their professional colleagues for jobs that could have been done by laymen. Usually where this occurred the National Foundation chapter was relatively weak or the professional people had not had much previous experience with volunteer service. In most places lay and professional groups combined their skills to a remarkable degree.

Volunteer Help

The volunteers' ingenuity in making this a festive occasion for the kiddies added some fun and frolic to the clinics' serious purpose. They gave children lollipops, cookies and lemonade, or ice-cream cones as rewards and helped teachers amuse them with songs and games while they waited in line for the needle's prick. In Texas some of the children who gave blood samples saw a free movie or had a ride on a fire truck. One town in Kentucky offered every child who gave blood a certificate of heroism, entitling him to one ice-cream cone at the corner store. Another community upped the bait to 10 cones. The awarding of Polio Pioneer cards and buttons to children who completed all three inoculations was the final pleasurable duty of men and women who had patiently performed more onerous tasks.



A nurse takes a sample of blood from a child before inoculation. The samples taken in the Pittsburgh preliminary tests showed that the vaccine increased the antibodies in the blood without ill effects to the child.

It was originally estimated that some 200,000 to 250,000 nonprofessional volunteer workers would be needed to supplement the services of approximately 14,000 school principals, 50,000 classroom teachers, 20,000 physicians, and 40,000 nurses. Probably many more volunteers than anticipated engaged in the work. The average over the country was 2 volunteers for every 5 youngsters in the test. In some instances, more volunteers turned up than needed, but it was easier to send some home to return another day than to try to fill a deficit by recruiting in the middle of the operation.

Wherever maximum community participation was secured, it had been preceded by joint planning meetings well in advance of the trial. The initial planning meeting, called by the health officers, included key professional and community leaders brought together to work out the administrative and medical aspects of the trial. Usually represented at this early stage—ideally 4 weeks before V (Vaccination) Day—were the local medical and pediatric societies, nursing council, schools, Government agencies, and the National Foundation chapter and local office.

A second type of community meeting brought together representatives of major community organizations; men's and women's service clubs, church groups, business and industry, and labor unions to present them with accurate information on the trials and to recruit volunteers for assignments.

Wherever this type meeting was omitted, preparations for the trial got off to rather a slow start.

Many other formal and informal meetings were held before the trial got under way, including parent's meetings at schools. A number of educational techniques were used on these occasions—speakers, films and filmstrips, question-and-answer panels, and group discussions.

Many briefing sessions also were necessary to explain and assign duties. Recordkeeping was a particularly knotty training problem. Volunteers were confronted with complicated and unfamiliar forms. The system of handling records on each child had to be followed rigidly, if there was to be any hope of the complete information and accuracy necessary to evaluation of the vaccine. The tardy filmstrip on recordkeeping was badly needed.

School nurses, teachers, and volunteers helped keep the records. Where there were enough recordkeepers sharing the work, all went well, but when one person tried to shoulder the detail alone, confusion and loss of time resulted.

After the clinics were closed, volunteers in many places rechecked the forms to spot any mistakes or omissions which could be rectified. Early reports from the team of evaluators at the University of Michigan indicate that they are satisfied with the records they are receiving.

Difficulties and Assets

Clinics that operated with ease and speed far outnumbered those in which difficulties arose. Representatives of the National Foundation staff, who moved from place to place, gave advice and help when the occasion demanded. If there had been more of these staff members available, and if they had gone into the field earlier, some of the deficiencies and errors might have been avoided.

Wherever a bad situation arose it was caused by a variety of circumstances: the trial got off to a late start; there was insufficient coordination between State and local health departments; health officials and doctors were not properly briefed; or instructions were not followed up by proper supervision. Communities which attempted to place direction in either doctors' or laymen's hands alone soon found themselves in trouble. Neither group could work without the other.

The psychological effect on the children was an early concern of the National Foundation. It was hoped that the stage could be set so that they might profit from a practical health lesson, and take pride in participating in an historic occasion, even though they naturally would not like being stuck with a needle.

As it turned out, the children proved to be willing and unusually cooperative participants when they had advance orientation for the inoculations. Difficulties arose, and fears became evident when they were not well enough prepared. Only in a few instances were tears caused by other factors. Children who had to wait in line too long, especially when they were anticipating blood sampling, built up fears and anxieties. As one youngster put it, "It wasn't the needle that hurt; it was thinking about it." But in most places, teachers and volunteers successfully distracted their attention.

Although most of the children first learned about the vaccine test at home, what happened in the classroom had a significant influence on their behavior while the inoculations were taking place. Teachers showed skill and imagination in interpreting a scientific subject in terms little children could understand. While some felt "the less said the better," the majority planned classroom discussions which were related to elementary health, social studies, and history. Many used the National Foundation's filmstrip, "Bob and Barbara," and some posted newspaper pictures of children who had taken part in Dr. Salk's early tests. They naturally related the polio vaccination to other protective shots the children had already received.

The idea of becoming "Polio Pioneers" soon caught on. Certainly the lollipops and other rewards helped. The fact that friends and classmates were all in this together was also a great incentive.

At the date of this writing—scarcely a month after the last school clinic—this unprecedented medical field study has not yet fallen entirely into perspective. The successes and failures stand out clearly, but the reverberations will teach more lessons as time goes on. Certainly, one principle has been thoroughly established—that nonprofessional volunteers can work side by side with the scientist. The trial has also demonstrated that communities can mobilize for the advancement of medical science as they can marshall their forces in time of war and disaster. Surely all this power and potential can be tapped again for the solution of other acute health problems.

An inter-Bureau committee probes the problems involved in . . .

SERVICES IN THE ADC PROGRAM

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AN INDIVIDUAL who has participated in a group process of thinking or action has difficulty communicating to others the flavor of the experience. It is hard to explain what happened in the course of the experience which brought about the conclusions and convictions which the group derived from it. One finds himself wishing that others could go through the same process. One asks, Would others come out at the same place we did and with the same conclusions?

This difficulty of communicating experience is now being faced by members of the working committee of the Bureau of Public Assistance and the Children's Bureau who for many months jointly considered various aspects of the Aid to Dependent Children program in some detail. Therefore, in attempting to present the highlights of committee activity, we as committee members want to emphasize our feeling that the process we went through was of equal importance with the conclusions we reached. Or, to put it another way, to reach any conclusions with which committee members could find intellectual compatibility, we had to seek the answers to a number of fundamental and interrelated questions. Search for such answers put many demands upon all members of the committee in a variety of ways. It imposed the need to rise above our respective programs, to observe the disciplines of our professional knowledge, and to realize many times that the meaning of words is not in the words themselves but in us.

The reader will want to know how and why this working committee came into existence. For a period of time prior to creation of the committee, public reaction to the ADC program indicated some dissatisfactions with the program. While reactions varied from State to State and within States, public concern was being expressed in many places about behavior of mothers receiving ADC grants which did not seem consistent with the standards the community held for the sound rearing of children. Question was also raised over whether parents were being encouraged to elude their parental responsibility.

In many instances it was hard to identify the origin of this public reaction or to determine the measure of its validity. Nevertheless the Commissioner for Social Security felt that it was important to mobilize the resources of the Social Security Administration, Department of Health, Education, and Welfare, in such a way as to insure maximum help to States in their administration of this federally aided program. Therefore a working committee was appointed composed of representatives from the Children's Bureau and the Bureau of Public Assistance. The broad charge to the committee was to consider services to children in ADC families and ways in which the cooperative activities of the two Bureaus could help in the development of more adequate services.

The committee was able to identify in logical sequence the major questions which it was going to

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have to answer for itself in attempting to carry out this charge. In essence these were:

What is the purpose and nature of the ADC program?
What kind of problems are faced by families receiving ADC?
What services are required to meet these problems?
What knowledges and skills are needed to provide these services?
What are the services appropriate to the ADC program?
What contribution can the child-welfare program make to the services needed?
What are present realities and how can they be reconciled with desirable goals?

The consideration of these questions raised other issues that could not be resolved without considerable struggle. Voluminous papers were written and cast aside. Many trails were retraced. Many differences of opinion had to be reconciled. Of major assistance to the committee through all this process was source material from the experiences of staff in the field of practice, from published and unpublished writings on various aspects of the ADC program, from policy material of the Bureau of Public Assistance, from Congressional reports, and from the Social Security Act. The committee also developed rather detailed working papers to clarify for itself the quality of casework services that would be required to meet the needs of some of the families receiving ADC.

Necessary Review

We began by examining the Social Security Act and Congressional Committee hearings and reports. From this we established that the core factor in eligibility for the program is financial need and that the way into the program was through doorways of family disruption—death or incapacity of a parent, divorce, or desertion. In other words, we found that this was not a pension or insurance program nor was it one where financial need had been occasioned merely by unemployment.

The purpose of the program as set forth in the Bureau of Public Assistance Handbook indicated that it was a program for the preservation of family life in which children would be afforded the opportunity to grow up in a setting of their own family relations and have an equal opportunity with all other children to realize their capacities and share in the life of the community.

From this knowledge of the purpose and the nature of the program it became apparent that the families receiving ADC might be expected to have a variety of problems with which they would need help if the purpose of the program were to be realized. The committee recognized that while many families applying for ADC were quite adequate, the fact of dependency alone was productive of problems for them, particularly since financial need was also accompanied by the loss or disability of one parent. In addition to their feelings about dependency, these families were faced with such other major problems as readjustments in their standards of living, loneliness for the parent who was gone, and the need of the remaining parent to be both mother and father.

The committee further recognized that some families had difficulties beyond the immediate problems which brought them to the agency. Often the circumstances resulting in desertion and divorce arose from profound and prolonged parental discord and personal inadequacy which had left its mark on the children and had produced adverse family and community relationships.

What then were the services needed? The committee found that, first and foremost, adequate financial assistance was essential since inadequate clothing and shelter and lack of enough to eat would impair social as well as physical functioning to such a degree that unless these basic needs were met the families could not deal effectively with other problems they might have.

But was the provision of money enough?

This question posed a basic and major issue to the committee. If provision of adequate financial aid was not enough, was there a responsibility within the ADC program to provide other needed services? In terms of present realities and the foreseeable future, could staff within the public-assistance program be equipped to provide the skilled services needed by some families receiving ADC? Should the ADC program limit itself to establishment of eligibility and provision of money payments and seek other service when required from other community resources? Did the Federal act include in ADC the responsibility for social services?

This forced us to retrace our steps and look again at the Federal act, Congressional Committee hearings, and at the policy statements previously issued by the Bureau of Public Assistance. We had to look again at the eligibility requirements for ADC and what these requirements meant in the lives of individuals seeking this aid. Each of us brought to the discussion about this issue our own ideas and feelings that grew out of our individual experiences or lack of experiences with the ADC program. We had to struggle with these points of view until we were able to rise above "program mindedness" and look objectively at the parents and children being served

through ADC and how this could be a constructive experience for them. We did not resolve all of the basic issues, but we did come out with certain conclusions that we all believed in and could support.

Some Conclusions

We recognized that the very factors that made families eligible for ADC were also sources of emotional feeling and family breakdown. In addition, economic dependence and the need to apply for financial assistance through ADC has social and emotional import. Eligibility could not be established without taking into account these emotional and social factors and without making judgments that require social-work knowledge and skills.

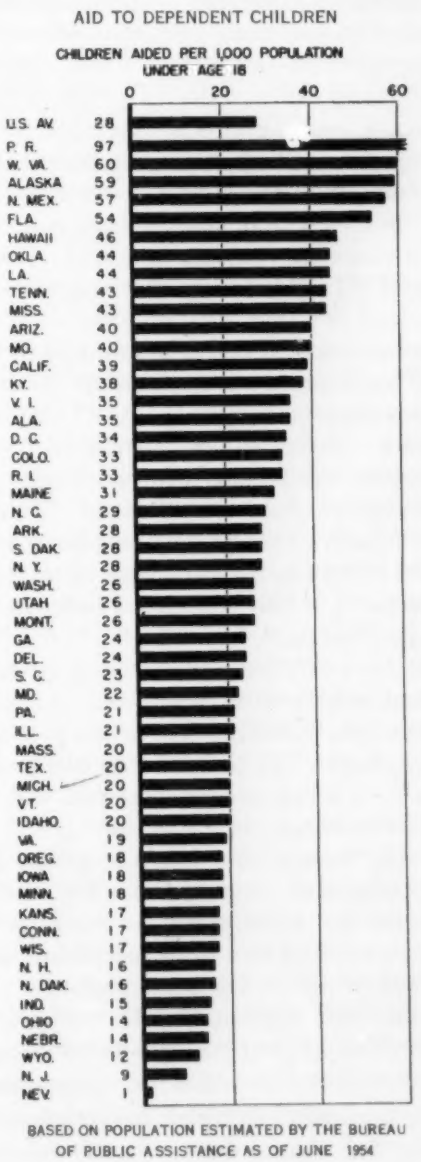
The committee believed that when the worker saw the applicant as a human being with feelings about the things that made it necessary for him to apply for ADC the worker could participate with him throughout the eligibility process with understanding, feeling, and respect for him as an individual. This would serve the applicant by helping him to evaluate and use financial and social resources he might not have recognized or made use of previously.

The committee concluded that the services in relation to initial and continuing eligibility should be available to all applicants and recipients in order to make the application for and receipt of assistance a constructive experience.

But what about the problems some people had beyond the immediate ones, which brought them to the agency? The committee recognized that these problems might often be complicated in nature, involving deep-seated emotional difficulties. However, we agreed that services needed and desired by these families should also be available if the ADC program were to achieve its fullest objectives—if the mothers of whom the community was critical were going to be helped to be good mothers and if wayward parents were to be helped to assume their proper responsibilities. It was our conviction that the needs of such families could not be met except by skilled casework help which, if it were not available in the public-assistance agency, would need to be sought from other sources in the community.

At this point the committee moved from talking about "services" to considering directly the skills and knowledges involved in providing them. After prolonged and careful consideration we became convinced that the purpose for which ADC was established and the eligibility requirements made it a program which required social-work knowledge, skills, and judgment. We believed that the use of staff without social-work education did not negate this fact. Family problems are no less real in areas where no social agencies exist, just as a person is no less sick because no doctor is available to care for him. The problem is—what to do about it?

Having reached this conclusion we had to widen our considerations beyond the worker and client to the setting in which they met. If ADC was a social-service program what significance did this have in terms of administration? The program, we agreed, must be administratively geared to its purpose and intent. This we thought meant conviction within the administration of the program that the public-assistance agency had administrative responsibility



for planning to meet those social-service needs that are related to the purposes of ADC. Administrative acceptance of this responsibility would be expressed through agency philosophy and administrative planning and would involve such aspects of administration as: suitable qualifications for staff; reasonable size of supervisory and worker loads; policies and procedures which were clear, consistent with each other, and related to purpose; and knowledge of and plans for use of community resources to meet families' needs which the public assistance agency itself could not meet.

Practical Steps

At this stage of developments the committee had the discouraging experience, not uncommon to social theorists, of having their deliberations received with something less than enthusiasm. The committee had been following the practice of clearing its conclusions with a wider group at intervals for reaction and perspective. Why, we were asked at this point, are you being so impractical and visionary? Where will you find the staff or community resources to provide all the services you have in mind? What States really need is help here and now with their day-to-day problems in administration.

The committee was not as unmindful of the "here and now" as it might have appeared. It recognized that, throughout the country, ADC staffs were in large part professionally untrained, sometimes supervised by others also professionally untrained and often carrying sizable caseloads. The committee was aware also that State public-assistance agencies varied widely in their concepts of the ADC program and in what they considered to be the scope of their responsibilities.

We felt, however, that a committee approach which was limited only to what States could accomplish at the present time would inevitably be a piecemeal and ineffective effort. We believed that what was needed were goals to which accomplishments could be related. Furthermore, in order for goals to have validity they would have to grow out of the legal base and purpose of the program. We realized that requirements for accomplishment were conditioned by the nature of the task to be performed as well as by the tools available for immediate use. We recognized that our dilemma in this respect was not unique since any enterprise which involves growth and improvement has objectives which may take some time to attain but which nevertheless serve as a blueprint for what is done on a day-by-day basis. Our confidence in our conclusions derived from the fact that the goals, as we saw them, were predicated not only on the legal base and purpose of the ADC program but also on what the field of social work had demonstrated could be accomplished for families with needs characteristic of those receiving ADC.

The next practical step for the committee to take seemed to be to consider how States might be given help in using the resources they now had available to move towards the goals we had thus far developed. This could take several forms. Our general thinking in this regard is perhaps best expressed by quoting an excerpt from the committee's draft report:

> **". . . Nevertheless such an application of principle to reality will give guidance to State public-assistance administration in policy formulation, in personnel planning, in determining the focus of staff-training activities, in the planned cooperative relationships which need to be developed with other programs and the lacks which need to be emphasized and stimulating community action.**
>
> **"Such an evaluation of the ADC program will bring to light strengths as well as weaknesses. It will suggest ways that staff can be, and are being, helpful to people even though skilled services directly related to a given need are not available in the community."**

Throughout our considerations the question of what could be expected of "untrained staff" in the ADC program was ever present. This seemed a problem well worth attention since progress in the ADC program would depend largely on the staff now working in States many of whom did not have professional training. Based in part on our knowledge of already demonstrated performance of staff in many States, we concluded that workers with certain basic educational and personal qualifications could acquire on the job enough understanding and competence to provide the services we saw as necessary to the eligibility process and could therefore make the provision of financial assistance a constructive experience. We felt that staff so equipped would be able to help families with concrete, tangible aspects of living so that positive changes would emerge in feelings and relationships within the family and in attitudes towards self and others.

We concluded, however, that a requisite to on-the-job acquisition of such competence was supervision from persons with professional social-work education and experience and a well-planned staff-development program integrated with administration.

The committee recognized that there are limits to how far staff lacking social-work education could be expected to go in providing casework services even under adequate supervision. We saw a need for more information gained through controlled experiments to determine more adequately what might be

expected of staff without social-work education, but with competent supervision, in providing casework services.

At long last, but equipped with the knowledge and perspective which our detailed study of the ADC program had given us, we felt ready to deal with that part of the Commissioner's charge to the committee relating to the question: How the cooperative activities of the Children's Bureau and the Bureau of Public Assistance could help States in the development of more adequate services to ADC families.

The committee was then forced to look objectively at the child-welfare-services program for which the States receive some aid under Title V of the Social Security Act. We recognize that child-welfare services were not available in all local communities throughout the country and that in some communities child-welfare workers lacked social-work education and experience and were no better equipped to provide skilled casework services than were the ADC workers with similar professional lacks. The limited staff available in both programs emphasized the importance of making maximum use of all the technical knowledge and skills both within the agency and from other community resources.

We completely agreed that both the ADC and child-welfare programs had mutual concern that social services be available when needed by families and children. We recognized that each program had its distinctive purpose and function and that cooperative relationships should further the purposes of both programs. We saw the contribution of the child-welfare program to the State public-assistance program taking place in a number of broad areas:

Joint planning between the two programs in orientation and continuing inservice training.

Cooperative planning between the field staff of both programs in carrying out their responsibility to local units.

Cooperative efforts in community planning in order to develop needed services and facilities for families and children.

Consultation from child welfare to the ADC program for the purpose of strengthening administrative, supervisory, and casework staff at State and local levels.

Cooperative handling of ADC cases in which the services of child welfare are needed.

The effectiveness of cooperative planning, we believed, depended upon its beginning in the States.

Eventually we reached a point where we felt it would be unproductive to work longer without sharing the results of our deliberations with staff actively engaged in the administration of the ADC and child-welfare programs. Accordingly a "draft committee report" was prepared and was sent out to the States. Currently regional Public Assistance and Children's Bureau staffs are making joint plans for discussions of the report in meetings with the State agencies. From such discussions the committee hopes to test the soundness of the concepts it has developed and to discover if there are important aspects of the ADC program which it has not yet taken into account. An equally important purpose of the Federal-State discussions is to share with State administration the process which the committee went through in reaching the concepts and conclusions in the draft report.

The committee is not sure it has come to grips with all the issues which must be faced in the administration of the ADC program, nor that all of its conclusions are unassailable. However, we do have considerable conviction about the process which is involved and the steps which must be taken in reaching sound conclusions about services in the ADC program.

While we believe that the content of the report will be useful to States, the degree of its usefulness will depend in large part upon each State public-welfare agency asking itself the same sort of questions which the committee explored nationally: What is the legal base and purpose of the ADC program in our State? What are the needs of people receiving ADC? What services are required to meet these needs? What resources do we have here and how to provide these services? What should be our plans for the future?

THE ADC PICTURE

Recipients and grants, July 1954

Families receiving ADC	581,179
Children receiving ADC	1,565,887
Average monthly grant per family (3.6 persons per family)	$85.26
Total monthly expenditures for assistance payments (from Federal, State, and local funds)	$49,550,875

Staff members in social-work positions

Since most members of social-work staff in public-assistance agencies work on a variety of programs, the exact number involved in the ADC program is not known. However, on the basis of time studies made by persons with undifferentiated caseloads, it has been estimated that an equivalent of 8,500 to 9,000 executives, supervisors, and visitors were working on ADC programs as of June 1954. Of the total public-assistance social-work staff of 30,000 in 1950, approximately 11 percent had had a year or more of graduate social-work training.

Emotional as well as physical needs concern . . .

THE NURSE IN THE CHILD-HEALTH CONFERENCE

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THE ROLE of the public-health nurse in the child-health conference has become steadily more challenging, interesting, and complex. In recent years the knowledge about how children normally grow, emotionally as well as physically, has steadily increased, and clues for recognizing danger signals in this normal growth process have been established. Emphases in health-department programs on accident prevention, early detection of mental retardation, hearing loss, and dental defects all find a natural focus in the child-health conference. The immunization program, an important part of the clinic, in many official agencies poses an almost overwhelming task for the public-health nurse, because of the number of patients involved. Along with these emphases has come a quickening of interest in the part that environmental and social factors have to play in normal growth and development.

Theresa Harder's article in the May-June issue of CHILDREN pointed up the role of the medical social worker in the child-health conference, as carried out in the District of Columbia Clinic. That clinic is fortunate to have the services of medical social workers who give direct services. This is not available for most clinics in the country, and in the absence of such a service the initiative of the public-health nurse is required to find social casework resources in community social agencies.

Increasing Demands

Perhaps none of the activities of a well-child conference are new to all clinics, but even where many have long been established the pressure on the clinic to intensify its activities increases as more people become cognizant of children's needs. Through in-service programs and advanced educational programs, public-health nurses are preparing themselves to meet more exacting demands for good child health care and are trying to apply new knowledge.

The public-health nurse in the child-health conference has a variety of functions. What these are, of course, depends upon the objectives, facilities, and personnel of each particular clinic. If administration stresses quantity of immunizations as a criterion of good clinic care, the public-health nurse, unless she is careful, may find herself unconsciously case finding and home visiting with this objective foremost. On the other hand, if the clinician is a pediatrician who is aware of the emotional as well as the physical development of the child, the public-health nurse can assume a different counseling role than she can under a doctor oriented only to the physical aspects of child development. If her agency encourages the use of volunteers, she will have more time for group teaching and observation of the individual needs of the mothers and children who go through the clinic. If she works in a rural area confronted by transportation difficulties and with few, if any, social-agency resources or special consultants available her emphasis will have to vary, according to what can best meet the clinic's objectives. Whatever the limitations of the clinic, the nurse must keep herself informed of the basic patterns of normal growth and development as the child matures, and be aware of all the resources that can be called into play when she finds deviation.

In the majority of child-health conferences, the nurse carries out many kinds of activities. She sets

up and manages the clinic. She is its hostess, responsible for greeting and seating the mothers and making them comfortable while they are in the waiting room, and for establishing the warm friendly atmosphere which makes it easier for them to use the staff services. She interprets the clinic services and policies to new patients and takes their social histories. She also records pertinent information on returning patients to help the doctor in his evaluation. She weighs and measures children and takes their temperatures when necessary. In many clinics, she gives immunizations upon the doctor's standing orders.

Supplementing and coordinated with the doctor's interviews she also interviews the mothers individually according to their needs and helps them anticipate their child's next stage of development. When referral elsewhere for another service is indicated she is usually the one to interpret this need to the mother. If a social worker is part of the clinic team, the nurse supports both the patient and the social worker in the referral process. Her home visits are often planned on the observation of needs revealed in the behavior of the mother and child at the clinic.

The nurse also conducts informal group conferences of mothers, where she may show and discuss movies on growth, development, and child care if the clinic has sufficient space and staff to allow it. If the clinic uses volunteers, she is responsible for orienting and helping them.

Post-Clinic Conference

While the physician is the natural leader of the clinic team, at times the public-health nurse may initiate joint planning on the part of the doctor, the social worker, and the nursing group toward streamlining the child-health conference to fit present-day concepts of care or in evaluating the services offered. In many clinics she participates in postclinic conferences involving staff discussion and planning.

These conferences are becoming more and more prevalent as a means of bringing together the experience and observations of the staff members, making a plan for patient care, and assigning staff responsibility for carrying it out. Providing an opportunity for generalized observations on similar problems, the conferences might be considered a continuous method of evaluating to what degree the total staff is meeting its objectives.

Postclinic conferences are most prevalent in teaching clinics where they offer the student doctor or nurse an opportunity to discuss questions presented

One of the nurse's many duties in a well-child conference is to interview new patients, as in this picture, interpreting the clinic's services and recording pertinent information about the mother, the child, and the family.

by mothers at the clinic, as well as general questions regarding any aspect of child health. Problems of specific patients are discussed from the total-care viewpoint, with the doctor presenting his concern about the preventive medical aspects, and the nurse contributing information about the health, environmental, and social situations she has observed in her home visits and the results of direct nursing services and demonstrations. If a social worker is present she usually functions in a consultant capacity, although occasionally she may be contributing direct casework services to the family.

These discussions require all members to be aware of the effects of the mother-child relationship on growth and development. In the ensuing planning decisions are made as to whether the family requires more help from a doctor relationship, a nursing relationship, or a social-casework relationship.

The following case illustrates the nurse's role in carrying out plans made for one mother through a postclinic conference.

When Mrs. S. brought 6 weeks' old Jimmy to the clinic the first time, she had a drawn, worried expression. The nurse in taking the brief social history required for admittance asked the mother whether she had ever attended the clinic before. Mrs. S., the mother of three other children aged 21, 17, and 13, said she had attended so long ago she had forgotten just what the clinic was like. When the nurse remarked that Mrs. S. must feel as though she were having her first baby, the mother said that she felt

silly having a baby at her age, that she had thought she was going through the menopause when her pregnancy began and that she had felt embarrassed around the older children. To the nurse's comment that it must be hard for her, Mrs. S. replied that she didn't know how she would manage. Asked if her husband and children were helping with the baby's care, she laughed nervously and said that her husband seemed proud of having another baby and helped as much as he could. She was afraid the baby was being spoiled for he cried a great deal, was very active, and slept very little.

Mrs. S. said she found the baby irritated her though she knew it wasn't his fault. She also worried about whether she was feeding him too much because he seemed hungry all the time. The nurse assured her that the pediatrician would be able to help with the feeding and would be interested in all her concerns about the baby's care.

At the scales Mrs. S. held the baby away from her as if she didn't know what to do with him. She sat at a distance from the younger mothers while she waited her turn with the doctor. All this produced an impression of insecurity which the nurse summarized briefly for the doctor.

At the postclinic conference, the pediatrician expressed concern about this mother and her relationship to the baby—a healthy, alert, responsive infant. Mrs. S. had told the doctor she hadn't wanted another baby, because she was too old and too nervous. The nurse remarked about the mother's difficulty in holding the baby for its first immunization. Mrs. S. had cringed and had awkwardly jiggled the baby up and down instead of holding it close to her as most mothers do.

It was at this meeting that a plan was made for the staff to see this mother every 2 weeks in clinic until observations indicated that she was more secure in caring for the baby. The plan also allowed for frequent home visits by the nurse if Mrs. S. seemed to want additional reassurance or demonstrations in any phases of baby care that were troubling her.

A social-work consultant available to the clinic was asked to talk with Mrs. S. at her next clinic visit to help evaluate the situation and to determine whether referral to a social agency was called for. She decided against referral, but identified intrafamily relationships that aggravated the mother's need for reassurance in her care of the child.

The plan of frequent nursing visits to the home proved to be successful. The nurse followed up any cues to the mother's insecurity, watched her feed and bathe the baby, and commended her when appropriate. Beginning to gain confidence in her adequacy to care for the new baby, Mrs. S. became more relaxed in handling him, and as time went on complained less of his activity and her own nervousness. As her ability to handle the normal problems of child care became evident to the clinic staff, the home-nursing and clinic visits were gradually decreased. Anticipating that this mother would need additional help in handling the child when he became more mature, active, independent, and negative, the staff encouraged her to get ready for this stage by participating in informal group discussions with mothers whose children were presenting normal problems of independence as well as with those who had younger babies. The nurse stimulated these discussions while the mothers were waiting to see the doctor.

Mrs. S.'s baby developed rapidly and she spoke proudly of his appearance and accomplishments. Her case illustrates the help that can be given to a mother through joint staff planning. In the beginning and throughout the contact, the mother's feelings of inadequacy and hostility toward the baby were recognized and accepted. Through the reassurance she received, she could eventually accept herself and her role of mothering with more satisfaction.

Mothers' Needs

Informal group discussions for mothers conducted by the public-health nurse in the clinic setting are becoming recognized as a helpful educational medium. When the clinic uses volunteers for more routine tasks the nurse's time may be freed for this purpose. Whether it is feasible to hold them depends upon the public-health nurse staffing pattern, the space available, and the ability of the nurse to encourage mothers to find solutions to their own problems rather than to offer direct advice.

The presence of other mothers makes it easier to help a woman who says of her wiggling 2-year-old: "I wish he were a baby again. I get so mad at him when he won't mind and sit still." She will show obvious relief when other mothers in the group tell her that their 2-year-olds are just as difficult and that they are having the same problem. As the mothers begin to recognize a common pattern of 2-year-old behavior the nurse can back up their relief with the reassurance that while it is a difficult stage it is also a normal stage of development. Mothers need an opportunity to express their frequent fears that their children are developing differently than others.

Mothers can also learn a great deal from hearing other mothers talk about their difficulties in handling normal growth and development problems. Questions about thumbsucking, toilet training, feeding, weaning, and other problems are discussed enthusiastically if the atmosphere is conducive to free expression on the part of the women present.

Mothers' Needs

The public-health nurse can informally invite the mothers to participate in such groups. While the choice of subjects for discussion can be left to the mothers, it is usually helpful to start them out on something they have in common. For example: "Most of you have 2-year-olds. What are some of the things you've noticed that are different about the baby since he is older?" As one or two mothers begin to participate, the others feel free to bring up problems bothering them.

When the group is held to about 10 the nurse learns from listening what each mother needs to know about stages of her child's development and may pursue the subject with her later.

For example, one of a group of mothers told of her 2-year-old son's masturbation. "I slap him and slap him, but it doesn't help. What else can I do?"

The other mothers were very critical of her actions. At this point the nurse asked how *they* handled this problem, thus shifting the focus from the punitive mother. Recognizing, however, how deeply troubled she was, the nurse talked with her later in order to reassure her that a great many mothers were faced with this problem and to let her know that she could discuss it with the doctor. In the ensuing interview the doctor was able to go a little further into the causes of her concern and help her accept the behavior as a normal phase of development.

Health teaching cannot be effective unless it is based on the needs of the patient at the time the information is presented. For instance, the nurse's need to emphasize good nutrition may not be in keeping with the mother's readiness to learn what she has to offer. This was true of a young mother with her first baby, age 8 months, who interrupted the nurse's review of diet with "Oh, he eats everything I give him, but when will he get his first tooth?" Dietary instruction was obviously lost on this mother until her concern about teeth had been reduced.

Since counseling produces the best results *after* a mother expresses her needs by questions indicating her readiness for help, public-health nurses are handling fewer routine individual conferences.

Nevertheless, in home visiting or in the clinic, health teaching is one of the primary functions of the public-health nurse. In order to help mothers learn how to keep their babies and themselves healthy, it is necessary to know a good deal about their motivations and about their attitudes regarding health—to find out why each mother is attending the clinic rather than to assume she is there for the reasons the staff would like her to be. Some mothers think of the child-health conference as the place where their children get immunizations, and others as a place where they have opportunity for a little socializing. Many mothers come to the clinic to be told the baby is doing well rather than to learn to do things differently so the baby can do better. The nurse's ability to teach health knowledge will depend upon how well she accepts the patient's original motives for coming to the clinic and her ability gradually to develop a relationship with the mother that helps her to expand her use of the clinic and staff.

One way of evaluating a child-health conference is to count the mothers who do not keep appointments once the immunizations are finished. The fact that they drop out of clinic at that point indicates how little they feel the rest of the child-health conference holds for them. Although many of the behavior problems in preschool children occur as the child is striving to use his developing skills independently during the so-called training period, in many child-

In visits to the home, as below, the nurse observes whether the physical and emotional environment is conducive to the child's healthy growth and discusses aspects of child care about which the parents may ask for help.

health conferences children beyond the toddler stage are rarely seen. Similarly home visits by the nurse are usually more frequent on the infant level and unless something pathological occurs the mother is left to struggle with the preschool period on her own.

Another evaluation can be made by periodically reviewing the notations on the record to determine what the patient's problems are and what help they have been offered. Unfortunately these sometimes show a repetition of staff "advice" for a year without any analysis of why the mother has been unable or unwilling to follow the suggestions.

Careful thought needs to be given in planning priorities for making home visits. Most young mothers of first babies quickly learn a great deal through caring for their babies. They welcome the nurse's visits and are relieved to discuss at rather frequent intervals what they and their babies are doing. Mothers of first babies are particularly apt to need help in understanding how children develop during the "training age" from 1 to 3.

Emotional Problems

Through her work in the child-health conference the public-health nurse has some responsibility for the early recognition of emotional disorders. Through observation and listening to the mother's expression of concern about her child, she can become aware of each mother's major problems. She can not only recognize what kind of a mother-child relationship exists but help plan what approach can be used to help the mother solve the problems she faces in relation to her child's growth and development.

In talking with the mother the public-health nurse must be nonjudgmental and refrain from giving routine advice, while supporting the strengths she finds. If she believes that the mother's problems are primarily of an emotional or social nature, she brings this opinion back to the rest of the clinic team which may help her plan for referral to an appropriate community resource.

When a social or emotional problem calls for referral to a social agency the nurse's responsibility involves preparing the mother for referral. To do this she must know enough about the agency's policy to help the mother anticipate what her first visit will be like and what she can expect in the way of help. It is important for the nurse to have a way of exchanging information with the agency to help the caseworker understand why the child-health-conference personnel made the referral and what information the nurse needs to carry out her functions.

Unhappily, too many agencies still have no easily workable interagency plan for interchange of information between staff members working with the same family although conferences between nurse and social worker are desirable on original referrals and sometimes as casework progresses. The public-health nurse often knows a good deal about the family interrelationships, the living conditions, and the attitudes that play into the problem situation that could help the social worker. The two can work out together where nursing responsibility ends and casework takes over, although there will be some unavoidable overlapping.

Lack of time is usually given as a reason why such conferences are not arranged, though in the long run time will be saved if the two agencies work together. Confidentiality is another reason given for failure to exchange information. Here a mutual respect of each other's professional area of competence is required. The public-health nurse may need to take more initiative in asking for conferences with social-work agencies until these agencies recognize her interest and her potential contribution.

The long waiting lists for services in most social casework agencies require the public-health nurse to give support to the mother while she is waiting to be seen. In rural areas the lack of resources is a real barrier to the nurse's efforts to find family services based on skill outside of the field of nursing. Only too often she looks into every possible source of additional help to no avail.

Cooperation

The public-health nurse through her contact with rural or neighborhood doctors can do much to cement good relationships between the health department and the private practitioner. She is well aware of the role the family physician plays in giving care when the child or other member of the family becomes ill, for the child-health-conference staff refers mothers to private physicians when a question of pathology arises. It is reassuring to the mother to know that the public-health nurse and private physician keep informed of each other's activity.

Though public-health nurses are constantly looking for new ways to improve their services to mothers and babies, they cannot do this alone. Joint professional planning, including citizen participation in community efforts, is essential to the improvement of services in the maternal and child-health programs.

How big is the problem of juvenile delinquency? the answer requires the complicated task of . . .

COUNTING DELINQUENT CHILDREN

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JUVENILE DELINQUENCY has been defined as "any . . . juvenile misconduct as might be dealt with under the law."[1] Under this definition the term juvenile delinquency is obviously viewed as a legal concept. Other and possibly broader definitions based on psychological and social constructs have been advanced, and these may be appropriate for special purposes. But for purposes of general measurement, the legalistic, restricted definition seems most useful.

If modification in the definition is needed, it is surely in the direction of further clarification. Misconduct, like any other type of human behavior, can hardly be measured apart from the persons exhibiting the behavior. The question then arises as to whether it is the number of occurrences or experiences we wish to count or the persons involved. The point of view taken here is that the basic unit of count should be persons and that the descriptions of their behavior should be related, but corollary, counts.

In the United States, laws relating to juvenile delinquency are set forth in the statutes of the various States. State statutes define not only the term "juvenile" but also the term "misbehavior" or "delinquency." The definitions of juvenile delinquency as contained in State statutes vary widely and describe with varying degrees of specificity acts ranging from those that if committed by adults would be felonies or misdemeanors, through the types of behavior which have no exact parallel in the criminal codes and which are open to a high degree of subjective interpretation, such as "incorrigibility" or "ungovernable behavior."

An attempt to count children in relation to their delinquent behavior immediately introduces a time factor that resides implicitly or explicitly in all counts of juvenile delinquency. Assuming that a child becomes a juvenile delinquent when he first begins to engage in "such misbehavior as might be dealt with under the law," how long is he to be counted as a juvenile delinquent? Should he be counted only while engaged in the interdicted act, until he is no longer a juvenile, or at some intermediate point?

In community practice, juvenile delinquents are generally counted at a variety of intermediate points, as determined by the needs and procedures of the operating agencies that learn about and deal with delinquent children.

The magnitude of a juvenile delinquency count depends in large part on where and when the count is taken. The number of children known as delinquents to organized agencies is obviously smaller than the number of total delinquents by the very large proportions that are not detected and apprehended. Likewise, the number of children known to juvenile courts is less than that known to the police

[1] From Report of the Committee on the Socially Handicapped, *Delinquency*, 1930 White House Conference on Child Health and Protection, p. 23.

by those children who are released before or after arrest and whose cases are disposed of in some way other than referral to the juvenile court.

The calendar year has gained considerable acceptance as the conventional reporting period for juvenile-delinquency statistics. If comprehensive and unduplicated counts of children known to agencies at any time during the year are obtained, we have the basis of an "incidence" count.

To make comparisons between geographical areas or between different periods of time in a given geographical area it is highly desirable to compute rates. To compute rates we need denominators as well as numerators. The proper denominator is, of course, the population at risk of being delinquent. For a given jurisdiction the population of juvenile-court age may be used, but because this varies among jurisdictions when rates for more than one jurisdiction are to be computed, a convention must be adopted defining a uniform age group. The problem of computing rates is in practice complicated by the difficulty of obtaining population estimates for local units for intercensal periods.

Juvenile-delinquency statistics, derived as they are from agency records, cannot indicate the extent of hidden delinquency and, therefore, of total delinquency.

Moreover, such data are apt to reflect differences or changes in the operation of the recording agencies, as well as or even more than differences or changes in the phenomenon of juvenile delinquency itself. We must be sure of our numerators before we proceed to compute delinquency rates.

"Why Count?"

The purposes of collecting statistics on juvenile delinquency may be generally organized in three large, somewhat overlapping, categories.

1. Public information. The public is interested in knowing the extent of delinquency. Public interest in the statistics is apparently greatest in regard to trend or even of change from year to year. Is juvenile delinquency going down? But, especially, is it going up? If counts are rising, interest in the nature of the problem is likely to be heightened, resulting in increased demand for comparative data for local areas.

The motivation behind public interest may range from generalized concern, alarm, and fear to disciplined efforts to study, plan for, and bring about effective social action.

Operating agencies, such as the police, the juvenile courts, and training schools, may use delinquency statistics to stimulate public interest in their programs, in discharging their responsibilities for reporting on their stewardship, to justify their requested appropriations, and to point up need for extension and improvement of services.

2. Administrative statistics. In addition to their public-relations use, delinquency statistics have important potential applications to other administrative purposes, namely, in program planning, managerial control, and supervision. However, little has been attempted thus far in relating counts of delinquency to volume and kind of services and to costs of providing them. When this is done, analyses may be made of utilization of staff and other agency resources, and in assessment of agency organization and operating procedures.

3. Research. A completely satisfying evaluation of programs for the prevention, control, or treatment of juvenile delinquency can hardly be made without knowledge of the nature and types of delinquency and factors associated with its various manifestations. For more than two decades global statistics on juvenile delinquency derived from the police and the courts have been chief materials used in epidemiological-type studies whose purpose is to explore the social factors associated with juvenile delinquency. The fashion in recent years has been toward the more intensive clinical or microscopic research. In these studies social forces are also considered, to be sure, but additional and perhaps chief emphasis is on the psychological aspects. In any event, the number of variables introduced have become manifold, thus reducing the relative importance attached by some investigators to the basic count of juvenile delinquents.

The Conference on Control of Juvenile Delinquency, called by the Children's Bureau in April 1952, pointed out that general statistics could not "give an understanding of the problem of delinquency needed to plan practical services," because they do not "adequately discriminate between the great variety of personality and behavior problems requiring different approaches on the part of the people developing programs of prevention and treatment." But that conference did recognize the validity of operational statistics for administrative use and suggest ways in which research could improve their quantity and potential usefulness for program

evaluation. In fact, attempts at controlled and other clinical-type studies are frequently based on samples drawn from police or court statistics, and sometimes from institutions or other agencies. Whether or not the samples are useful for the problem under study depends to a large extent on the validity and the reliability of the population data from which they are drawn.

The objectives of juvenile-delinquency statistics are then to provide public information, administrative guidance, and a basis for research into the etiology of delinquency and into the administration of programs for treatment, prevention, and control.

How Are We Doing?

To what extent have the objectives of juvenile-delinquency statistics been achieved thus far? A description of the current scene may serve as background to a consideration of this question.

Police data. Since 1930, the Federal Bureau of Investigation has obtained reports from local and State police, both in summary form and in the form of individual fingerprint records. Until 1952 the individual fingerprint records were the only data collected nationally that described the social characteristics of persons arrested, that is, age, sex, and race. It was from the fingerprint card showing age of persons arrested that the FBI obtained its counts on juvenile delinquents and youthful offenders. Inasmuch as many communities, by law or practice, do not fingerprint children who are arrested, FBI statistics were far below the number of children actually arrested in the reporting communities.

In 1952, the FBI published for the first time data on age, sex, and race of persons arrested obtained from summary reports rather than from individual fingerprint arrest cards. These data are intended to represent all children arrested, whether or not they have been formally charged. In regard to these data the FBI states: "A number of departments whose reports were used in the tabulations volunteered the information that there were other agencies in the community which on occasions detained juveniles under circumstances amounting to technical arrest, which activity was not reflected in the police age, sex, and race of persons arrested report. Thus, it is quite probable the arrest figures herein presented, while far more complete than comparable data obtained from an examination of fingerprint arrest records are still conservative in the lower-age groups." [2]

Notwithstanding these limitations, it is clear that the discrepancy between the number of children arrested and those reported by a given community has been significantly reduced with the shift from fingerprint arrest cards to summary reporting of personal characteristics. Based on fingerprints and records the number of children under 18 reported as arrested in 1951 was about 37,000. The number in 1952 under the new summary reporting procedure was about 86,000—even though the 232 cities reporting that year represent only 15 percent of the Nation's population.

The increase in the number of children reported as arrested represents an important gain in the completeness of reporting by those police departments included in the FBI series. It is highly probable, but not certain, that this increase has resulted in a more accurate picture of arrests of children. Reports from local police departments through the FBI are on a voluntary basis. The data obtained represent neither a total count nor a sample of all cases, but rather an undetermined portion or "chunk" of the total.

The FBI publication *Uniform Crime Reports* shows that for 1953 the reporting areas cover about 42 percent of the urban population. While the report does not show the geographical distribution of the arrests, the FBI has made such information available to the Children's Bureau in a special tabulation. The data show that in comparison with the general coverage for the country as a whole, some regions are overrepresented while others are underrepresented. The Middle Atlantic States are rather seriously underrepresented, as are the Southern Central States. In terms of size of city, the FBI series is overrepresented for medium-sized cities and underrepresented for both very large and very small communities. The effect of this disproportionate coverage on the data reported cannot now be determined.

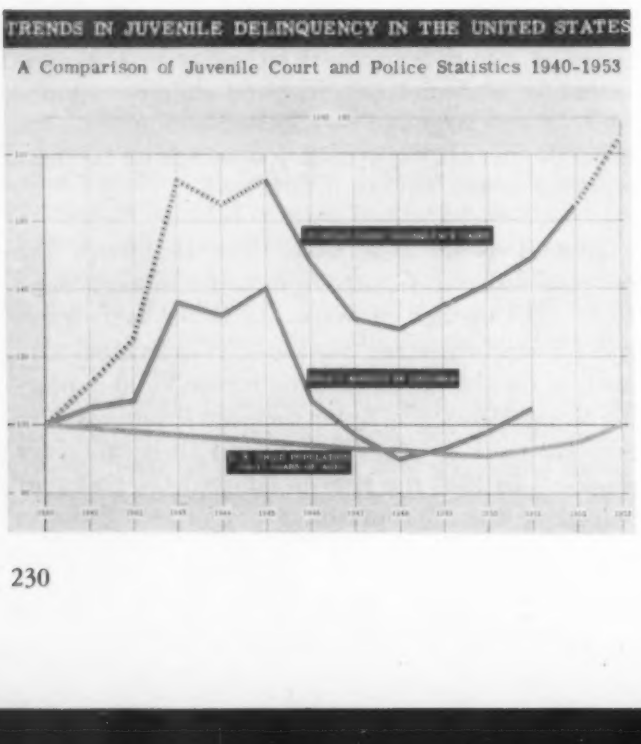
Juvenile-court reporting. The Children's Bureau has collected reports from juvenile courts since 1926. The method of collection in the early years was for each reporting court to send individual data cards to the Bureau on each delinquent child appearing before the court. Later the courts were asked to tabulate their own data and send their summary reports. In 1946 the Bureau adopted the policy of requesting the appropriate agency in each State to

[2] Uniform Crime Reports. Washington, D. C.: Federal Bureau of Investigation, vol. 23, no. 2, 1952.

act as a collection and summarizing agent. In 1952, in an effort to increase the number of reporting areas, and on the advice of the Children's Bureau Advisory Committee on Juvenile Court Statistics, the amount of detailed information requested was drastically reduced. Such items as age of child, reason for referral to the court, type of detention care, and disposition of case were eliminated. Attempts to obtain unduplicated counts of children known to courts were postponed. The reports now call only for information on the number of children brought before the court for reasons of delinquency, dependency, and neglect, whether handled officially or unofficially, and on sex of children in delinquency cases.

The number of courts reporting rose from 458 in 1951 to 586 in 1952. At the same time the proportion of the child population of the country 10–17 years of age covered by the series increased from 23 to 29 percent.

An important technical limitation on coverage in the Federal-State reporting series is the seeming inability of many courts to obtain counts in cases handled "unofficially," that is, by court personnel other than the judge. Because practices concerning selection of cases to be heard by the judge of a juvenile court vary widely from court to court and even within a given court over a period of time, the reporting of "official" cases only may be a misleading count. The present practice of the Children's Bureau is to include in the regular Federal-State reporting series the reports of only those courts that report both official and unofficial cases. However, the Bureau publishes special tables including the counts of courts whose reports are made up of official cases only.



The juvenile-court series shares with the police-arrest series the disability of not representing a definable sample. Like the Federal Bureau of Investigation series the Children's Bureau reports are overrepresented for some regions and underrepresented for others. For example, the Middle Atlantic, the Southern, and the Mountain States are all seriously underrepresented in the juvenile-court series. The series is also underrepresented in counties having less than 10,000 population.

The apparent bias on the geographic coverage of the juvenile-court series seems somewhat similar to, but not identical with, that in the police-arrest series. The correspondence in specific communities covered by both series is however quite low. For example, of the 106 largest cities in the country (over 100,000 population) only 25 are included in both the juvenile-court and police-arrest series. Of the remaining cities this size, 31 are reported only to the Federal Bureau of Investigation, 18 only to the Children's Bureau, and 32 to neither. Furthermore, the age and sex distribution of the children in the two series varies widely.

A noteworthy phenomenon is the way in which the two series move together from year to year. This can be seen on the chart "Trends in Juvenile Delinquency in the United States" (see chart). At no time for which we have data have they moved other than in the same direction. Among the possible explanations for this are the following:

1. The correspondence in the direction of change in the two series is fortuitous.

2. The correspondence is due to common determinants in the two series, but these determinants contain such systematic error that neither series has any meaningful relationship to actual changes in the phenomenon being measured.

3. The correspondence is due to common determinants in the two series and both series have a positive relationship to actual changes in the movement of juvenile delinquency in the United States.

The Bureau favors the third interpretation. The probability of fortuitous correspondence, the first interpretation, is so low as to rule it out of practical consideration. However, our choice between the second and third interpretations, that is, our feeling that the series reflects real change, is based only on our observations that the data seem to make some

sense. This subjective feeling is not, of course, good enough for meeting the purposes of juvenile-delinquency statistics. Moreover, as the chart indicates, there is no positive agreement on the magnitudes involved. Although we may place some reliance in the correctness with which the series indicates whether delinquency is increasing or decreasing, the data do not give any clear picture of the actual size of the problem at any one time or from year to year. The available national statistics on juvenile delinquency constitute, in effect, a measuring instrument somewhat like a weathervane, which shows the direction of the wind but not its velocity.

In the hope of obtaining a measure for the volume of juvenile delinquency, the Children's Bureau Advisory Committee on Juvenile Court Statistics recently recommended that consideration be given to establishment of a national sample of juvenile courts for reporting purposes. The establishment of a sample will have additional values. It should make possible speedier estimates than can otherwise be obtained. By focusing attention and assistance on the courts in the sample, it may be possible to elicit at intervals some of the desirable descriptive data that was abandoned in the interest of greater coverage in the total Federal-State recording system.

The proposal to establish a sample of courts contemplates that the regular Federal-State reporting system will also be maintained, because of the values to the States in becoming familiar with statewide information on juvenile delinquency.

The most important current development in the juvenile-court series is the work now in progress in designing, with the valuable assistance of the sampling experts of the Bureau of the Census, an efficient national sample of juvenile courts for statistical-reporting purposes.

Such a sample will make available reliable estimates of the size of the juvenile delinquency load in the courts of the United States. The sample will give appropriate consideration to courts in the different regions of the country and to courts in rural places as well as in larger towns and metropolitan areas. If the sample is to give results with a margin of error of say, less than 5 percent, on estimates of the total volume of delinquency known to courts, it will be necessary to include all of the largest courts in the country—that is, the 60 largest courts or all of those with jurisdictions of 50,000 children or more. Many of these courts and some of the courts which will be selected to represent the smaller places are not now currently in the Federal-State juvenile-court reporting system. Considering the size of the problem and resources available for the job, the Bureau expects to have the sample reporting system installed in preliminary form by 1956.

Other Statistics

The two other national collections of data pertaining to juvenile-delinquency statistics are those of the Bureau of Prisons of the Department of Justice on children charged with violation of Federal laws and data on children in training schools collected by the Bureau of the Census in 1950. The latter represents the first national census of the population of training schools for delinquent children since 1933, and makes possible some important measures of the changes in the 17 intervening years. The Children's Bureau has recently completed a special survey of the characteristics of these institutions.

A complete inventory of data on juvenile delinquency in States and in local communities is not yet available. Impressions gained from the operation of the juvenile-court series, some field consultation, and review of publications is of a slow and rather fitful growth in reporting coverage. A considerable amount of recent growth has apparently been stimulated by statewide agencies interested in youth and child welfare. The pioneering efforts in Ohio, Michigan, and Missouri toward complete statewide juvenile-court reporting have been emulated in a number of other States. Statewide juvenile-court systems in Connecticut, Rhode Island, and Utah have emphasized better statistical reporting.

A recent article in the *Journal of Criminal Law, Criminology, and Police Science*, entitled "An Accounting Plan for Juvenile Probation,"[3] describes an ambitious attempt to obtain complete and accurate reporting of probation services in California. The current experience of the New York City Youth Board in operating a register of delinquent children known to agencies is one of the more interesting local developments in juvenile-delinquency statistics.

States, and especially local communities, need and can use far more detailed information on juvenile delinquency than would be appropriate to gather nationally. The design of an efficient system for the reporting of juvenile delinquency in this country would provide a broad base of information in local communities with increasingly selective use of these data by State and National organizations.

[3] Volume 43, Number 6 (March-April 1953), pp. 705–718.

An essay-review . . .

UNDERSTANDING ADOLESCENTS

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GUIDING THE ADOLESCENT is at once an important and exceedingly complex task. Learning how to help children develop during the early years is important and complex too and one might expect that as they advance in age the task would become somewhat simpler. There are many reasons, however, why this does not happen. For instance, guiding the adolescent involves assisting him in making decisions about problems that baffle adults as well as teen-agers. We adults can reach considerable agreement as to how to help very young children adjust to the simple physical and social environment they face and we can keep our home and school environments under control so that these adjustments are well within the limits of the young child's abilities. But the adolescent is entering an uncertain, complicated, and troubled world. Helping him to understand the problems of achieving independence, engagement and marriage, finding a job, building a philosophy of life is as difficult as life itself.

The new booklet for parents entitled "The Adolescent in Your Family,"[1] recognizes both the complexity and importance of guidance at the adolescent level. It brings together a variety of knowledge about development at this age and formulates suggestions as to how parents can assist the adolescent in adjusting to physical changes, assuming responsibility, achieving independence, developing constructive relations with peers, adjusting to the opposite sex, and planning the educational and vocational steps toward a happy and useful life.

Past literature on adolescence fails to bridge an apparent disjunction between research findings on the one hand and daily-life situations on the other. For example, the usual college textbook will present elaborate graphs showing how scores on an intelligence test will, on the average, increase with age throughout the teen years. But it never comes to grips with the problem of why in spite of this increase in intelligence some adolescents will show such "unintelligent" judgment as to drive 90 miles an hour through downtown traffic.

Similarly the usual text may go to great length to show how height, weight, chest girth, and size of ovaries and testicles change during the adolescent years, but will not tackle the problem of how the adolescent can adjust to the wide individual differences in the various aspects of physical growth. Studies of adolescent problems indicate that the physical and physiological changes in and of themselves do not cause difficulty, but rather the attitudes people take toward them. The usual text, however, fails to consider the origin of these attitudes or ways of overcoming them.

On the other hand, the text more than likely refers to a rapid increase in growth of the body in adolescence, ascribing to this the prevalent problem of awkwardness and thus overlooking available data which indicate that the various parts of the body do not all grow at the same rate nor do some individuals shoot up as suddenly as others. Such an assumption also ignores data suggesting that changes in scores on tests of motor coordination are not correlated with gains in height or weight. The usual discussion does not consider the question of why awkwardness should appear when scores on motor coordination tests do not decrease.

The new bulletin of the Children's Bureau represents a much more effective integration of research findings and the daily problems of adolescents than has been usual in the literature of the past. For example:

Boys and girls don't fall over their own feet, blush, and drop things because they are growing so fast or so unevenly. . . . lack of gain in coordination at this

time isn't because of physical growth; like other bodily functions, such gains have different rates of growth at different times. Any physical awkwardness when a young person is growing fast is likely to be associated with the new self-awareness. It is much more a matter of social awkwardness than of lack of skill in managing his body. Given a setting in which a boy is unself-conscious—when he's swimming or driving a hayrake for example—he has no trouble making his muscles work together. But if he can't have his clothes replaced as fast as he grows out of them, or if constant comments are made about his big feet, or long arms, he may feel awkward indeed in group situations.

Another problem of analysis and synthesis that has plagued the writers on human development has been the complexity of human behavior when they are faced with describing the difference between what children do, under various cultural conditions, and the meaning of the behavior for the individual. Literature for parents too often assumes or implies that what most adolescents are doing or do frequently is "normal." Thus there are tabulations of the frequency of conflicts with parents, the unrealities in vocational ambitions, the extent of masturbation, or avoidance of study of high-school mathematics. However, since the origins of any form of human behavior are complex, before we can approve, disapprove, condone, or condemn we have to know something about the underlying causes, about how the behavior pattern developed and what it means to the individual.

This booklet on adolescence represents a distinct step forward in emphasizing a more fundamental approach to behavior. For example, in regard to the use of money it says:

. . . Attitudes toward money are built up partly on the basis of emotional needs. When a boy or girl spends excessively or unwisely, hoards, or shows any other striking attitude toward money, parents might want to consider underlying causes. Why is it that one boy needs to impress his friends by picking up the check for a double-date stop for hot dogs? Why does he feel the need of this kind of recognition by his peers? Why does a certain girl cautiously cling to her money as though it were a life-preserver? What other way can be found of giving her the security she seems to find in being miserly?

The same emphasis on understanding what is behind behavior appears in the discussion of drinking:

If drinking threatens to become a problem, the concern of parents should be to discover why a young person needs the transient sense of well-being and the false sense of importance that alcohol lends . . . Anyone whose inhibitions are such that he must try to get rid of them to feel happy needs help. Such help can come only from people whose training has fitted them to unravel the causes of the fears and doubts the person has about himself . . .

Throughout, the bulletin stresses the influence of various environments—home, school, community—on the adolescent's development, an emphasis that has been affirmed by research findings during the last 15 years. It also refreshingly calls for recognition of the adolescent's ability to weigh the pro's and con's of his daily problems:

When we set down rules, they should be rules that our children shared in making. Our teen-agers are fully capable of thinking through such problems as hours for coming home at night, sharing the use of the family car, and other such questions. If rules are made only to bring peace of mind to ourselves, there is little incentive to live up to them.

Thus, the bulletin will help parents appreciate that the adolescent can take part in building his own environment, that everything does not have to be done for him, that he can understand and take hold. The possibility of guiding the young person to learn more about his social environment, including the behavior of himself and others, has been encouraged by recent research. As a result, materials are now appearing designed to help adolescents gain more understanding of the forces that operate in human behavior. After parents have become thoroughly familiar with this possibility they may want to provide such materials for their teen-agers. Some of the recent pamphlets that have appeared in the Public Affairs series and in the Science Research Associates series may be of interest at this point. Other sources of this type of material are State departments of health, college and university extension divisions, and State mental-health societies.

In guiding the adolescent, as in guiding children of any age, the personal adjustment of the parent is an important prerequisite to success. Since problems at the teen-age level require much analysis and weighing of evidence, the emotional freedom to consider several sides of a question becomes doubly important in a parental discussion with an adolescent. Parents can obtain help from parent discussion groups and the extensive literature on personal adjustment that is now available.

Thus the new booklet, "The Adolescent In Your Family," finds a central place in starting the parent in his task of understanding and effective guidance.

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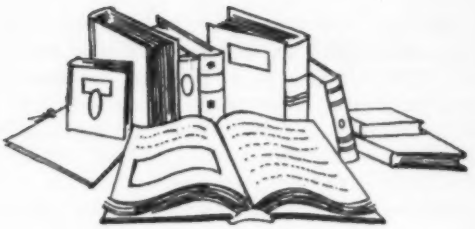
[1] Children's Bureau, U. S. Department of Health, Education, and Welfare: The adolescent in your family. Pub. 347, Washington, D. C.: U. S. Government Printing Office, 1954. 114 pp. 25 cents.

BOOK NOTES



CHANGING CONCEPTS IN CHILD CARE; professional papers presented at the Jewish Child Care Association of New York, held at the New York Academy of Medicine, January 7, 1954. The Association, New York. 78 pp. $1.50.

"Today it is rare indeed that a child comes to us for placement only because the family or its remnants has no means of support," says the executive director of the Jewish Child Care Association of New York, describing changes in the association's practices over the past two decades. Pointing out that public programs such as Aid to Dependent Children and services such as family counseling have virtually eliminated the economic causes of removing children from their own homes, he defines present-day placement as "a protective service required by particular children under particular circumstances."

The book devotes a chapter to each of three types of foster care provided by this agency: Specialized foster-family care for emotionally disturbed children whose behavior could not be tolerated in ordinary foster homes; cottage-type institutional care for emotionally disturbed children; and institutional care for the mentally retarded.

NEW DIRECTIONS IN SOCIAL WORK. Edited by Cora Kasius. Harper & Bros., New York. 1954. 258 pp. $3.50.

A number of contributors to this symposium give their ideas on the present state of social work, each charting the course that he believes the profession should follow in the future. Among the subjects treated are the responsibilities of a socially oriented profession, the changing functions of the voluntary agency; guiding motives in social work; and the responsibility of government to promote the welfare of the people.

According to the editor, "the authors, looking at the field from various angles, seem to be in general agreement that the profession is in need of a basic overhauling."

The book was prepared as a tribute to Philip Klein on his retirement from the New York School of Social Work.

PARENT COOPERATIVE NURSERY SCHOOLS. Katharine Whiteside Taylor, Ed. D. Bureau of Publications, Teachers College, Columbia University, New York. 1954. 257 pp. $2.85.

In her preface, the author says that this book "makes no attempt to duplicate the excellent volumes on nursery-school techniques and procedures already available, but deals rather with the unique values and problems of parent cooperatives and the insights and processes found most helpful for their operation. It seeks to give parents the basic orientation that will make the contributions of other books and teachers more meaningful, and to give teachers suggestions that may be helpful in working with parents."

THE ENCYCLOPEDIA OF CHILD CARE AND GUIDANCE. Edited by Sidonie Matsner Gruenberg. Doubleday & Co., New York. 1016 pp. $7.50.

More than half this book is prepared in encyclopedia form, with the subjects alphabetized—from "Abilities" to "Youth organizations." Most of the remainder consists of articles, by different authors, on basic aspects of child development. Many additional sources of information are listed—public and private agencies, and books and pamphlets.

THE JUVENILE IN DELINQUENT SOCIETY. Milton L. Barron. Alfred A. Knopf, New York, 1954. 349 pp. $5.

In his preface the author says that the solution of the juvenile-delinquency problem, "like that of other social problems, depends on an orderly modification of the American social structure and some of the values and functions of American society." Part I defines the problem, offers statistics, and considers the dynamics of delinquency, with special reference to the business cycle and the cycle of war and peace. In part 2, which takes up the causes of delinquency, the author indicates as the key chapter the one titled "The Delinquent Culture of American Society." Part 3 discusses detection and detention, the juvenile court, and institutional and other treatment, and concludes with a chapter on programs and techniques for preventing and controlling delinquency. The book is designed primarily for use as a text in courses on delinquency and criminology.

JUVENILE OFFICER. Capt. Harold L. Stallings, with David Dressler. Thomas Y. Crowell Co., New York. $3. 1954. 247 pp. $3.

Through a series of case histories, Capt. Stallings, who is with the Los Angeles County Sheriff's Department, conveys an idea of the complexity of police work with juveniles. As for the background of delinquency, he considers the family the greatest influence for good or evil—"it makes delinquents and also makes wholesome children."

PEDIATRIC PROBLEMS IN CLINICAL PRACTICE; special medical and psychological aspects. Edited by H. Michal-Smith; with 14 contributors. Grune & Stratton, New York. 1954. 310 pp. $5.

According to Dr. Howard A. Rusk's introduction, this book is addressed "not only to pediatricians, but to all physicians, psychologists, social workers, and teachers concerned with the health and welfare of children." The chapters cover problems of the emotionally disturbed, the schizophrenic, the mentally retarded, the brain-injured, the cerebral-palsied, the orthopedically handicapped, the allergic, the cardiac, the diabetic, the epileptic, and the tuberculous. A chapter on the sick child and one on the normal child are also included.

PROJECTS AND PROGRESS

New Laws Affecting Children

Children are affected, directly or indirectly, by a number of laws passed by the 83d Congress, which adjourned August 20, 1954. These included, among others, measures affecting social-insurance benefits, juvenile delinquency, hospital construction, education, school lunches, and income-tax deductions.

Insurance. January 1, 1955, large numbers of children will be added to those already receiving protection against the death of their parent-breadwinner under the Social Security Act, since Congress amended the act to bring about 10 million more workers into coverage of the Old Age and Survivors Insurance program. The amended act also increases OASI benefit payments. For example, a child previously receiving an $18.80 monthly benefit will now receive $30 a month. (Public Law 761.)

Juvenile delinquency. In a move to combat juvenile delinquency Congress made a $75,000 supplementary appropriation to the Children's Bureau to assist States and communities in improving services and facilities for delinquent children. (Public Law 663.) It also directed the subcommittee on juvenile delinquency of the Senate Judiciary Committee, originally scheduled to end its work February 28, 1954, to continue until January 31, 1955; and provided an additional $175,000 for the committee's investigation. The committee's appropriation was $44,000.

Housing. The National Housing Act of 1954 (Public Law 560) authorizes 35,000 units of low-rent public housing in addition to those under existing contract. The law restricts the new units to communities that have active slum-clearance programs.

Safety. Public Law 385 makes it a Federal offense to "bootleg" fireworks into a State where they are illegal.

Indians. Administration of health services for Indians and the operation of Indian hospitals is transferred from the Bureau of Indian Affairs, Department of the Interior, to the Public Health Service, Department of Health, Education, and Welfare, by Public Law 568. The law permits such facilities to be transferred under certain conditions to State, local, or private agencies for operation.

Hospitals. Aid to the States for hospitals and health centers has been broadened by an amendment to the Hospital Survey and Construction Act of 1946 which provides funds for the construction of four types of facilities for the chronically ill and impaired. (Public Law 482.) The appropriation includes: $2 million to help the States survey needs and develop programs; $6½ million for diagnostic and treatment centers; $6½ million for additional hospitals for the chronically ill; $6½ million for rehabilitation centers; and $4 million for nursing homes.

School lunches. The Agricultural Act of 1954 authorizes the Commodity Credit Corporation to give surplus food commodities to nonprofit school-lunch programs. It also authorizes $50 million of Commodity Credit Corporation Funds to be used annually for the next 3 school years to serve milk to children in nonprofit schools of high-school grade and under. (Public Law 690.)

International programs. For international programs during the fiscal year 1955 which directly or indirectly affect children Congress appropriated the following: for the United Nations Children's Fund (UNICEF), $12,500,000; for United Nations technical assistance $9,957,621; for similar programs under the auspices of the Foreign Operations Administration of the United States Government $105,000,000.

Physically handicapped. Congress amended the Vocational Rehabilitation Act to expand the program, both financially and in kinds of services. By 1958 the program may involve $65 million in Federal funds, which may be distributed to the States on a variable grant basis. (Public Law 565.) Supplementary appropriations of $4 million for grants to the States and $900,000 for training personnel bring the program a total of $27,900,000 for the fiscal year 1955. (Public Law 663.) Of 56,000 people rehabilitated under this program in the last year 12,000 were under 21.

Education. Public Law 530 authorized a White House Conference on Education, to be preceded by State conferences. For this purpose, $900,000 was subsequently appropriated, of which $700,000 is to be allotted for the State conferences. Public Law 531 authorized the Commissioner of Education to arrange with educational institutions and agencies for a joint program of research in education. Public Law 532 authorized the Secretary of Health, Education, and Welfare to appoint a National Advisory Committee on Education.

Congress also extended for 2 years the time allowed under a previous law for use of Federal funds for school construction in communities near military reservations and other places affected by Federal installations (Public Law 731), but made no additional appropriation.

Tax exemptions. In the revised tax law (Public Law 591) changes in the definition of "dependents" for whom deductions of $600 each can be claimed enable parents to claim more deductions than under the former law. A son or daughter whose parent furnishes more than half his support is considered a dependent regardless of the child's earnings: if he is under 19 or if he is over 18 and is attending school or college or receiving on-the-farm training.

A working parent who is a widow or widower is allowed an additional deduction up to $600 for the expense of caring for each child not yet 12 years of age. Such a deduction is allowed also to a mother who must work because her husband is incapacitated, or to a married couple whose combined income does not exceed $5,100.

For the first 2 years after the death of a spouse, the widow or widower who has a dependent son or daughter will be entitled to the same income-splitting privilege as is accorded married couples.

A taxpayer can claim a $600 dependency deduction for a foster child or a child living in the taxpayer's household while awaiting adoption, or for a cousin who is cared for in an institution because of physical or mental disability, if he had previously been a member of the household.

—SARAH L. DORAN

Birth Weight

The first national study of survival of the newborn in relation to weight at birth has recently been completed by the National Office of Vital Statistics, Public Health Service, Department of Health, Education, and Welfare.

The report is based on data for births in the first 3 months of 1950 and neonatal deaths among these children.

Statistics in the study indicate the magnitude of the immaturity problem in the United States and the level of mortality among both the immature and mature infants. Babies weighing 2,500 grams (5 pounds 8 ounces) or less at birth represented only 7.4 percent of all births in the study but accounted for two-thirds of the neonatal deaths. The neonatal mortality rate among these infants was 173.7 per 1,000 as compared with 7.8 among all other children. The lowest mortality (5.6) was experienced by children 3,501–4,000 grams (7 pounds 12 ounces–8 pounds 13 ounces). Detailed data by race, sex, plurality, attendant at birth, and period of gestation also appear in the report. Copies are available from the National Office of Vital Statistics.

Mentally Retarded

A number of recommendations to improve the lot of New Jersey's mentally retarded have been recently made in the final report of a 3-year-old gubernatorially appointed State commission on the problem. These include: immediate establishment of at least two more institutions to relieve the serious overcrowding in the State's four public training schools for the mentally deficient; better salaries and living conditions for institutional employees; establishment of courses for professional workers in this field, as well as scholarships, fellowships, and inservice training programs.

The commission has also urged the expansion of two State programs for the mentally retarded: the "home training service," a program which now employs three teachers to work with retarded children and their parents in their own homes; and the "service center plan," which in a center away from the institution helps institutionally trained girls prepare for free life in the community through a "vacation" or a trial period of employment.

The commission has also recommended that the Department of Education take more responsibility for the education and training of mentally deficient school-age children; that the new Bureau of Research in the Department of Institutions and Agencies employ qualified personnel for research in prevention and control of mental deficiency; that a coordinated list of mentally deficient persons be maintained.

The report notes that a number of steps have already been taken in line with the commission's recommendations, among them the earmarking of $10,000 by the Department of Education for a statewide census of all handicapped children.

Adoption

First steps in New York State's announced intention to bring about improved adoption services were taken recently by the State Department of Social Welfare when it appointed an adoption consultant to each of its five area offices. Their job, according to an announcement from the department, is to carry on a "continuing analysis of adoption possibilities; extensive training in adoption services; pooling of homes, children, and resources; and improvement in the staffing and organization of public adoption facilities."

The plan looks to the development of joint adoption services by counties in an effort to offer opportunities for adoption to children now in foster care. The State Department of Social Welfare has announced its intention to share with local welfare departments the costs of necessary additional staff for tasks essential to adoptions.

Staff Selection

In response to a long-time need expressed by State public welfare agencies for help in improving their methods of selecting social workers, the Children's Bureau and the Bureau of Public Assistance recently held a 2-week workshop for State staff responsible for interviewing candidates for social-work jobs. The workshop, which was financed in part by the Field Foundation, was held at the New York School of Social Work, August 23 to September 3, under the leadership of Sidney Berengarten and Irene Kerrigan of the school's staff. Sixteen State public welfare departments were represented.

The purpose of the workshop was to train selected State representatives in interviewing applicants and in assessing their personal suitability for social work. As a part of the workshop process the participants interviewed a number of applicants who had volunteered to take part in this procedure.

In evaluating the applicants' suitability for social work the interviewers used criteria that had been developed as the result of a 5-year research project sponsored by the New York School of Social Work. These criteria give special emphasis to such personal factors as emotional maturity, flexibility, and the ability to relate to a wide range of people. The criteria are being used by schools of social work in selecting candidates for admission, and are beginning to be used by State public welfare departments in selecting personnel for social-work positions.

Migrants

Last summer three Western States joined hands to provide continuity of health care to some thousands of children of migratory agricultural laborers. As part of a health program for all migrants at Fort Lupton, Colo., the children under 6 years old in the labor camp were given the first of a series of injections to immunize them against diphtheria, whooping cough, and tetanus. By the time the next injection was due, a month later, some of the families had moved into other parts of Colorado as well as into Wyoming and Montana; and the local health departments of those places, at the request of Colorado's Department of Public Health, completed the series.

Other phases of the Fort Lupton health project covered adults as well as children and included medical, X-ray, and laboratory examinations for communicable diseases; treatment of persons with venereal disease; and hospitalization of the tuberculous. The project was carried on by the Public Health Service, of the U. S. Department of Health, Education, and Welfare, in cooperation with Colorado's State Department of Public Health and the Weld County Health Department.

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The Colorado Department of Health has recently designed a program to provide services to families of migrants in counties throughout the State, with emphasis on maternal and child health. Planned to go into operation next summer in a number of counties the program will provide or arrange for immunization services, obstetric services and some other types of medical care through existing facilities or, where there are none, in newly developed facilities. Follow-up by arrangement with other States, as occurred in the Fort Lupton project, will be encouraged.

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During much of the past summer about 50 children of migratory agricultural laborers working in Potter County, Pa., were served by a day-care center established as a direct result of the Conference on East Coast Migrants held in Washington last spring.

Soon after the conference, the Governor's Interdepartmental Committee on Migrants, which represents Pennsylvania's health, education, welfare, labor, and other departments, met with the Pennsylvania Citizens Committee on Migrants and other voluntary agencies to plan followup action. The group decided to operate a day-care center, as a pilot project, in Potter County, where about 200 children of migrant families were due to arrive for an 8-week stay.

Officially sponsored by the Interdepartmental Committee, the center was supported financially by two departments—Welfare and Labor and Industry—and by the Pennsylvania Citizens Committee. Small fees were paid by parents.

Though only a small fraction of the children in the migrant group could be served at the day-care center, it proved so valuable that it won first place in a national competition for community projects as an outstanding example of joint planning between public and voluntary agencies. The Pennsylvania Citizens Committee on Migrants, for its efforts in promoting the center, was awarded $5,000 by a foundation.

Besides the Citizens Committee, other agencies that contributed to the success of the center included the Governor's Committee on Children and Youth, the American Friends Service Committee, the Pennsylvania Council of Churches, the Division of Home Missions of the National Council of Churches of Christ in the U. S. A., and the National Child Labor Committee.

Unmarried Mothers

As a step toward improving adoption practices, Los Angeles County's Committee on Unmarried Parents has recommended measures leading to a sound program to help unmarried mothers and their babies. The committee recommends: additional casework service for the estimated 1,000 unmarried mothers who each year give away babies without protective service; arrangements between social agencies so that no mother is denied service; financial help—emergency and long-term—for these mothers and their babies; community payment for medical care when other sources are lacking; foster-family homes for temporary shelter before and after the baby is born; central statistical reporting to determine the need for services; research into the underlying problems that lead to relinquishment of babies for adoption; and planned public information on the need for support of programs for unmarried mothers.

The committee is part of the Citizens Adoption Committee of Los Angeles County.

The cameraman shoots a juvenile-court scene for "HARD BROUGHT UP—a Child Welfare Story," a film produced for the Mississippi State Department of Public Welfare by Potomac Film Producers. This 40-minute black and white sound motion picture, reveals the whole spectrum of child-welfare services, focusing especially on a child-welfare worker's efforts to help unravel the personal and family problems of two delinquent boys. Interpreting child-welfare services to the layman, the film is also useful for staff training, orientation, and recruitment. Prints may be purchased from Filmbuilders, Ltd., 1536 Connecticut Avenue NW., Washington, D. C., or rented through film libraries.

Retrolental Fibroplasia

A 3-year study of the causes of retrolental fibroplasia is to be made by the National Society for the Prevention of Blindness, with the help of a $15,000 grant from the E. Matilda Ziegler Foundation for the Blind.

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Results of 6 months of study in 18 hospitals of the relation of oxygen to retrolental fibroplasia were reported at the annual meeting of the American Academy of Ophthalmology and Otolaryngology in September. In this period 72 percent of the 53 premature infants surviving 6 months after receiving routine oxygen treatment developed retrolental fibroplasia. Only 30 percent of the 245 surviving infants in a limited-oxygen group developed the disease. The two groups showed no difference in mortality.

The study, which is continuing, is being sponsored by the National Institute of Neurological Disease and Blindness, of the Public Health Service, Department of Health, Education, and Welfare; the National Society for the Prevention of Blindness; and the National Foundation for Eye Research.

Population

According to current estimates by the United States Bureau of the Census, the Nation's child population is growing bigger each day, with an average daily net gain of close to 4,700 in the number of children under 18 years of age.

Other Census Bureau estimates indicate that in 1954 the number of children under 18 years of age reached a new high of almost 54 million—an increase of more than 13 million, or 33 percent, since 1940. The most striking increases occurred among the children under 5 years of age (70 percent) and those 5 through 9 years (53 percent).

Between 1954 and 1965 the number of children under 18 is expected to rise by approximately 25 percent—to a total of almost 67 million. In this period the number of boys and girls 10 to 17 years old is expected to increase by about 50 percent, as the large number of children born in the late 1940's and early 1950's enters the age group 10–17 years.

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An estimated 38 million children and young people—23 percent of the total population of the United States—will be enrolled in schools and colleges during the school year 1954–55, according to S. M. Brownell, Commissioner of

Education, U. S. Department of Health, Education, and Welfare. Enrollment in elementary schools will be greater by 6 percent over last year; in high schools, 3 percent; in colleges, the number enrolled is expected to increase by less than 1 percent.

Nutrition

A 3-year study of food habits in New Mexico, carried out cooperatively by the State Agricultural Experiment Station and the Maternal and Child Health Division of the State Department of Health, has recently been completed. Undertaken with the purpose of helping nutritionists, home-demonstration agents, and health and welfare workers in their efforts to achieve better nutrition in their communities, it revealed an excessive use of sweets and insufficient use of protein and vitamin-C rich foods throughout most of the State. The information was gathered at well-child conferences; at maternity, orthopedic, school, and preschool clinics; and from written records kept by school children.

A report of the study has been issued as Bulletin 384 of the Agriculture Experiment Station, New Mexico College of Agriculture and Mechanic Arts.

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In 1953 the number of local health departments employing full-time nutritionists increased by 15 percent over the figure for 1952, according to information gathered by the Children's Bureau.

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For the first time a regional workshop has been held for professional nutrition workers in such varied fields as agricultural extension, education, industry, research, and public health. The 3-week workshop was held last summer at Virginia Polytechnic Institute. Alabama, Arkansas, Florida, Louisiana, Maryland, North Carolina, South Carolina, Tennessee, Vermont, and Virginia were represented.

Operating Costs

Recently released figures from a number of organizations show the effects of post-World War II inflation on the costs of providing services to children. Data collected by the American Hospital Association reveal that hospital expenses jumped 136 percent between 1945 and 1953. Salaries of medical personnel in State health departments rose 63 percent between 1947 and 1953, according to figures from the Public Health Service, Department of Health, Education, and Welfare. Statistics collected by the National League for Nursing show comparable rise—60 percent between 1945 and 1952—in salaries of public-health nurses in county health departments. Similarly, the statistical reports received by the Children's Bureau show a 57 percent increase between 1946 and 1953 in the salaries of child-welfare workers in public welfare departments.

Health Careers

With the financial support of the Equitable Life Assurance Society of the United States, the National Health Council recently launched a nationwide project known as Operation Health Career Horizons to interest young people in preparing for jobs in health services. The medical and health professions are also cooperating in the work.

Information on professional, technical, and supporting jobs in the health fields will soon be made available to young people and their families—high-school graduates, high-school students, and college students—as well as to vocational-guidance counselors, teachers, administrators in high schools, colleges, and universities, and to community leaders and the general public.

Heart Conference

About two-thirds of the 244 children who were improved by the Blalock-Taussig operation at Johns Hopkins Hospital for the "blue baby" congenital heart condition were maintaining their gains 5 to 8 years later. This was reported at the Second World Congress of Cardiology, which met at Washington September 12–18, along with the 27th scientific sessions of the American Heart Association.

Followup lasting from 3 months to 4 years was reported on 69 of 86 blue babies who underwent an alternative operation, devised by Sir Russell Brock of England. Virtually all of the 69 showed improvement.

New heart operations have made motherhod safe for many women in whom serious heart disease would have ruled out the possibility of successful pregnancy a few years ago, Dr. Curtis L. Mendelson of New York stated. Most of the heart damage among young women of childbearing age is caused by rheumatic fever, said Dr. Mendelson, and this condition now lends itself to corrective surgery.

Reminding the group that blue babies are highly susceptible to tuberculosis, Dr. S. D. Doff, of Jacksonville, Fla., recommended that precautionary X-rays be taken of all persons who come into contact with them, whether in the home or the hospital.

Visiting Specialists

Thirty-seven specialists in maternal and child health or child welfare who have come to the United States under the auspices of the Foreign Operations Administration, the World Health Organization, or the United Nations, are currently studying or observing operations in this country under programs arranged through the Children's Bureau. Most of these specialists are from countries where work to improve health and welfare is just beginning to take on national importance.

The largest number, 14, have come from the Middle East; 12 are from Latin America, 6 from Europe, 3 from the Philippines, and 1 from Japan. Twenty-three are concerned primarily with health, including 4 who are in medical social work; 14 are mainly interested in some aspect of social services for children or youth.

Twenty-four of the visitors are enrolled in educational institutions in various parts of the United States—11 in schools of public health, 11 in schools of social work, 1 in a postgraduate course in a school of medicine, and 1 in a school of dentistry. Three are on hospital staffs, as assistant resident physicians, interne, and externe. The remaining 10 are observing programs in various facilities throughout the country.

Home Safety

Georgia's State Health Department is carrying on a demonstration project in home-accident prevention with the help of a grant from the Kellogg Foundation. Staffed by a medical director, an engineer, a nurse, a public-relations officer, and a clerk, the project is using the regular channels of instruction in maternal and child health—well-child conferences, mothers' classes, midwives' classes, and home visits.

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Home safety for babies and preschool children is also being promoted in New

Jersey, where the State Congress of Parents and Teachers, the New Jersey Safety Council, and the State Health Department are cooperating in a joint program. First step in the program was a questionnaire distributed to 30,000 homes in an effort to learn about parents' attitudes and judgments in situations involving accident hazard. The findings are now being tabulated by the National Safety Council.

Institutions

Upon recommendations by the Child Welfare League of America, the Children's Village, Dobbs Ferry, N. Y., a voluntary residential treatment school for disturbed and delinquent boys, with a capacity of 300 children, has reorganized its program and administration. The institution has reduced the number of children accepted, scheduled the activities more flexibly in order to meet the boys' individual needs, and integrated the educational, child-guidance, and cottage-life programs in accordance with sound treatment principles.

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Completion of a new wing at the Astor Home at Rhinebeck, New York, will considerably enlarge the capacity of this residential treatment center for emotionally disturbed children, now accommodating 27 patients. Operated by the Catholic Charities of New York, the home is one of three pilot projects of this type sponsored by the New York State Mental Health Commission.

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Children's Services of Connecticut, a private child-caring agency, has reorganized its program to provide institutional services to emotionally disturbed children. The institution has four cottages with a capacity of 15 children each. Besides a full-time psychiatrist and a psychologist, the personnel includes a social worker for each cottage.

Crippled Children

Ninety-nine percent more children with congenital heart defects received physicians' services under State crippled children's programs in 1953 than in 1950, according to reports from State services for crippled children. Another large increase—77 percent—took place among children with eye conditions; and an increase of 69 percent among those with epilepsy. The group with orthopedic handicaps increased only 11 percent, but in both years this group made up more than half the children served.

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Michigan's Crippled Children's Commission is cooperating in the program of the U. S. Army Prosthetic Research Laboratory in developing prosthetic appliances for children with amputations. The State program is developing molds for the manufacture of smaller-size hands, to be made according to the specifications of the research group.

Here and There

Nearly half (48 percent) of the 3,187 counties in the United States had no full-time public child-welfare worker in 1953, according to reports from State welfare departments. Thirty-six percent had less than 1 such worker per 10,000 children under 21, and only 16 percent had 1 or more per 10,000.

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Japan's Children's Bureau, in the Ministry of Welfare, has published, in the Japanese language, the Digest of the Fact-Finding Report to the Mid-century White House Conference on Children and Youth.

SOME INTERNATIONAL PUBLICATIONS

STUDY ON ADOPTION OF CHILDREN; a study on the practice and procedures related to the adoption of children. United Nations, Department of Social Affairs. New York. 1953. 103 pp. For sale by International Documents Service, Columbia University, 2960 Broadway, New York 27, N. Y. 75 cents.

At the invitation of the United Nations, the International Union for Child Welfare, Geneva, collected the material for this study, which is based on answers to a questionnaire sent by the Union to its member agencies and other child-welfare agencies in a number of countries. Included in the report are information and conclusions brought out at a conference held in Geneva in 1952. It also contains some discussion of legislation on the basis of an analysis made by the United Nations, to be published separately.

An effort was made to cover countries with different legal systems and different social and cultural patterns. Eight European countries, three Canadian Provinces, three States in the United States, and five Latin-American countries are represented.

This study is one aspect of a larger United Nations study of children deprived of normal home life.

MENTAL HYGIENE IN THE NURSERY SCHOOL; report of a joint WHO-UNESCO Expert Meeting held in Paris, 17–22 September 1951. United Nations Educational, Scientific, and Cultural Organization, 19 Avenue Kléber, Paris 16, France. 1953. 36 pp. 20 cents.

Ninth in a series on Problems in Education, this report discusses such subjects as the child's needs and the role of the mother in the early stages, the role of the nursery-school teacher, recruitment, selection, and training of nursery-school teachers. In a final paragraph on public opinion the report says that "the nursery school itself, by doing its work properly, can probably make a more far-reaching impression upon public opinion than can any mass public-information campaign."

EXPERT COMMITTEE ON POLIOMYELITIS; first report. Technical Report Series No. 81. World Health Organization, Palais des Nations, Geneva, Switzerland. April 1954. 69 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 50 cents.

"It is not surprising," says the Expert Committee on Poliomyelitis, in this report, "that news of fresh discoveries in laboratory methods and in the epidemiology and control of poliomyelitis should arouse widespread interest. It was primarily to consider the place of these discoveries in future efforts to control the disease that the committee was convened."

As a necessary step in this direction, the committee in its first report reviews current knowledge and opinion on various aspects of poliomyelitis, "so that theories which can no longer be considered valid could be discarded and replaced by interpretations in keeping with the observed facts."

READERS' EXCHANGE

JUVENILE COURTS: Bad illustration

I would like to call your attention to the picture of a Juvenile Court hearing on page 133 of the July–August issue of CHILDREN. ("Parents and Delinquency," vol. I, no. 4.)

This would seem to picture a hearing as it should *not* be rather than an ideal type of juvenile court hearing. The better type of juvenile courts today all conduct their hearings in a roundtable fashion with the judge and 11 parties participating seated on the same floor level. Nothing so brands a juvenile court as out of date and old-fashioned as to have the child with a uniformed officer, together with the parents, stand before the judge as in an ordinary police-court hearing. We believe an organization such as the Children's Bureau should *set* standards rather than picture improper standards.

It is rather a hobby of the writer to try to modernize juvenile-court procedures and get away from old police-court type of hearings, which are now entirely passé in the better-type courts. With the judge and all participants seated on floor level and in a roundtable type of hearing, parents and children are placed at ease, the truth is more easily procured, and the welfare character of the court is emphasized.

I have described this in more detail in an article, "Helpful Practices in Juvenile Court Hearings," in the June 1949 issue of *Federal Probation*, published by the United States Department of Justice.

Walter H. Beckham, Judge, Juvenile and Domestic Relations Court, Miami, Fla.

YUM: What about results?

In her article on the Michael Reese Nursery Louise Yum gives us a picture of an excellent therapeutic nursery school for cerebral-palsied children. ("A Nursery School for Cerebral-Palsied Children," CHILDREN, Vol. 1, No. 4.)

As Mrs. Yum makes clear, the school's objective is for each child to develop on a par with his own possibilities into a healthy and whole personality. However, she omits two subjects of concern to anyone planning a therapeutic nursery school or already operating one. The Michael Reese nursery school, with its capacity of 14 and its large staff of specialists is clearly an expensive operation, offering optimum service. It would be useful to know just what results have been achieved. Some quantitative as well as qualitative information on results would help persons attempting to establish nursery-school programs of maximum effectiveness on limited budgets.

Secondly, Mrs. Yum notes that the school was originally established as a demonstration and experimental center. It would also be of service to many readers to know what information is available on results in these two areas of the school's program and where the information can be found.

Lawrence J. Linck
Executive Director, National Society for Crippled Children and Adults, Inc.

CAPLAN: A simple principle

The prenatal clinic described by Gerald Caplan ("Preparation for Parenthood," CHILDREN, vol. 1, no. 5) is guided by a simple universal principle—that every experience in life makes a psychological impact. This impact may be for better or for worse. In the past for the most part the psychological impact of the prenatal clinic has been unplanned and its effects have been left pretty much to chance. Depending largely upon the intuitive capacity of a staff, it might turn out to be good or bad. The work has been routinized and so has not varied with the needs of the case. Nor was this impact considered to be a part of the scientific armamentarium of the clinic harmonized with the needs of the child or his parents.

In this Harvard program the psychological aspects of the clinic are controlled just as the diet would be. Furthermore, the examination of the patient is designed to reveal his psychological needs. In order to accomplish the desired result it is, of course, essential that the members of the clinic team function as a unit, all pulling in the same direction. In this clinic the team effort is facilitated by the avoidance of overspecialization. Each member of the team is supposed to know enough about the fields of the other members of the team so that he can incorporate in his work the simpler functions of the others that are common to the group.

The clinic is impressed with the unfortunate impact of some current aspects of parent education. It seems that the stress on the importance of parental affection for the child is stirring up undue emotions of guilt and anxiety among parents. It is good to know that our communications are reaching parents. The next step is to make our communications as constructive as possible.

George S. Stevenson, M. D., National and International Consultant, The National Association for Mental Health, New York, N. Y.

BECK: Service and sacrifice needed

I have just read the report in CHILDREN on the recent Washington Conference on Juvenile Delinquency ("Steps to Combat Delinquency," by Bertram M. Beck, CHILDREN, vol. 1, no. 5).

We study and talk about and legislate about juvenile delinquency as though it was some specific situation which could be remedied by the application of a formula or prescription when, as a matter of fact, juvenile delinquency is a symptom and we will reduce juvenile delinquency only as we improve the heritage and environment in which our children are born and raised.

The attack on juvenile delinquency is an attack on all deleterious influences, but more than all that, it must be an attempt to revive and maintain the spirit of service and sacrifice among our American people. A democratic civilization cannot survive on the theory that the Government will provide for everyone. The Government is made up of all of us and only as we contribute to and work for a democracy can we expect to receive its benefits.

Sanford Bates, Consultant on Public Administration, Trenton, New Jersey.

Photo Credits

Pages 213 to 215, National Foundation for Infantile Paralysis.

Pages 223 and 225, Singer for the Department of Health, Education, and Welfare.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

CHILDREN'S BUREAU STATISTICAL SERIES. Single copies available from the Bureau without charge.

Juvenile Court Statistics, 1950–52. No. 18. 1954. 20 pp. This issue shows graphically and in tabular form how the volume of juvenile-court cases of delinquency increased in 1952 for the fourth consecutive year. From 1951 to 1952 the rise was 10 percent; for the period 1948–52 it was 28 percent. Juvenile-court cases of dependency and neglect increased 4 percent over the figure for 1951, continuing a rise which began in 1950.

Selected Child Welfare Expenditures by State and Local Public Welfare Agencies, 1952. No. 19. 1954. 17 pp. The data indicate that nearly three-quarters of the money spent by State and local public-welfare agencies went for payments for the support and care of children in foster care, the rest for professional services and for administration.

Diagnoses of Children Served in the Crippled Children's Program, 1950. No. 21. 1954. 26 pp. Among 214,000 children served in 1950 by State crippled children's programs aided by Federal funds diagnoses were established in 93 percent, this report shows. Four major diagnostic groups accounted for two-thirds of the impairments: congenital malformations; diseases of the bones and organs of movement; poliomyelitis; and cerebral palsy.

Personnel in Public Child Welfare Programs, 1953. No. 20. 1954. 14 pp. Three percent more full-time professional workers were employed in public child-welfare programs in 1953 than in 1952, but at the end of 1953 vacancies were still numerous, according to this report.

Educational Leave in the Public Child Welfare Program, 1952. No. 22. 1954. 22 pp. The study reported was conducted jointly by the Children's Bureau and the Bureau of Public Assistance of the Department of Health, Education, and Welfare. It shows that in 47 States 500 persons employed by State and local public child-welfare agencies concluded educational leave in a year ending August 31, 1952. They represented 10 percent of all the persons in the agencies employed full-time in social-work positions.

JOB GUIDE FOR YOUNG WORKERS. U. S. Department of Labor, Bureau of Employment Security. 1954. 46 pp. 30 cents.

Addressed to young people, this bulletin contains information on beginning jobs in fields of work where thousands of opportunities occur each year for boys and girls—jobs that require not more than a high-school education.

YOUR CHILDREN'S FEET AND FOOTWEAR. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder 41. 1954. 13 pp. 10 cents.

This illustrated folder offers help to parents in caring for their children's feet. It includes an 11-point guide to use when buying shoes for a child.

MOTION PICTURES ON CHILD LIFE; supplement No. 1. Compiled by Inez D. Lohr. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 16 pp. 15 cents.

This supplement includes annotations to 58 films that have become available since the original bulletin came out, in 1952.

MEDICAL SOCIAL SERVICES FOR HOSPITALIZED CHILDREN. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 28 pp. Processed. Single copies available from the Children's Bureau.

This pamphlet presents principles and agreements growing out of a discussion among medical social workers in State maternal and child health and crippled children's programs and in hospitals.

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